Handbook for Hospital Board Members of the Coast Provincial General Hospital, Mombasa, Kenya

2000

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This report was made possible through support provided by the US Agency for International Development, under the terms of Contract Number 623-0264-C-00-7005-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

HANDBOOK

FOR
HOSPITAL BOARD MEMBERS

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*** To be added by Administrator**

HOSPITAL BOARD MEMBER HANDBOOK

PURPOSE

To familiarize newly appointed board members with key elements of the hospital and board functions in order to provide a foundation of information and understanding in preparation for the Board's roles and responsibilities.

ORIENTATION OF NEW MEMBERS

Each new Board member will go through an orientation program consisting of the following general topics:

SESSION #1 - Presented by the administrator

History of hospital and scope of services offered, general role of the Board member, Board Bylaws, Mission Statement, Organizational charts

SESSION #2 - Presented by the administrator

Medical Staff Bylaws, functions of Board, Management, and Medical Staff. Medical staff credentialing process.

SESSION #3 - Presented by the deputy administrator, finance

Review of budget and process. Financial statements, financial audit, other insurance and payor information.

SESSION #4 - Presented by personnel officer and coordinator, quality assurance

Review of employee handbook, staff complement, compensation package, and quality assurance program.

SESSION #5 - Presented by the administrator

Review goals / objectives of the hospital's strategic plan and annual progress review.

HOSPITAL BOARD

ORIENTATION / TRAINING

STRENGTHENING BOARD AND MANAGEMENT RELATIONSHIPS

THE HOSPITAL GOVERNING BOARD

INTRODUCTION

A board of trustees is established in the hospital, working as the link between the hospital and the community it serves

The hospital board of trustees has the ultimate authority and responsibility for patient care and the overall quality of service in the hospital.

To fulfill this responsibility the board has the obligation to demonstrate leadership in determining the hospital's mission and in establishing a strategic plan that is consistent with that mission and with the resources available in the community.

The board shares its leadership responsibility with the executive management and medical staff to establish the hospital as the organized center for improving the health status of the community.

The structure and composition of the board and the policies and procedures it follows to ensure the orderly conduct of its business are critical in fulfilling the hospital's mission and goals to serve the community.

The composition of the board is of great importance; therefore, the board should establish procedures for the selection of members. Members should be selected on the basis of ability to serve the hospital and community effectively, not to represent particular interests or groups.

The board also should establish an orientation program for new board members and continuing education programs to keep members current on key issues.

HOSPITAL BOARD ORIENTATION

HOSPITAL BACKGROUND: Ministry of Health (MoH)

MoH HOSPITAL COST SHARING PROGRAM:

- Fee for service policy introduced December 1989

- Rationale: Government unable to continue unlimited free care due to-
  - insufficient budget allocations
  - rising costs of health care
  - increasing population
  - increasingly complex burden of disease

- Cost Sharing Objectives
  - generating additional revenue to improve services
  - creates incentives for patients to use primary & preventive services

- Retention and Control of Cost Sharing Revenue
  - best option when funds are retained and controlled by the community (local board) to improve the facility and services
  - this is a strong incentive for the provider to collect and patients to pay
  - the incentive for patients to pay is enhanced when they know the revenue is being used to improve services at the facility
  - collection incentive is weakened if the Government allocation is reduced, thus leaving the facility no better off

MoH HOSPITAL DECENTRALIZATION – INSTITUTIONAL AUTONOMY

- Rationale:
  - Improving communication and reducing administrative bureaucracy and thereby improve government's responsiveness to local needs
  - Enhancing effectiveness and efficiency of management by allowing greater discretion
  - Increasing the role of local community in ensuring governance while operating outside the day-to-day control of the MOH, but with the physical assets owned by the MOH, and operating under MOH policy, framework, and protection

GENERAL ORIENTATION

1.0 WHY CREATE A BOARD?

- To establish a focus for institutional responsibility – it is the law to establish a board to assume responsibility for hospital affairs
- To provide a subs titute for centralization of management by government
- Make decisions that will maintain and improve the hospital's survival and ensure continuity
- Implement permitting legislation / legal acts
- Boards represent the organization's owners –
  - stakeholders in non profits
  - shareholders in for profits
- Boards are accountable for the hospital organization- everything the hospital does, and everything that goes on inside of them

Boards have no ability to perform the actual work of their organizations - they see to it that such work is done by delegating tasks and authority to management and the medical staff.

Management and medical staff are responsible/accountable to the board for their decisions and actions.

2.0 WHO SHOULD BE ON THE BOARD? See Legal Notice 162, 5/92: 7-9 members.

- **One with experience in finance and administration from within the District**
- **Two nominated by NGOs - 1 religious, 1 private**
- **One nominated by Local Authority**
- **Not more than 3 representing community interests, and**
- **Area Med. Officer of Health, as secretary to the board**

Term of Office – 3 years and eligible for reappointment.

The Minister shall appoint one member to be Chairman

3.0 CANDIDATE SCREENING CRITERIA - related to the task of selecting new members:

- Do the members have the skills and the experience required to form a strong board?
  Skills related to operational concerns of the hospital (finance, medical staff)

- Is the board effective? If not, why not? Poor leadership? Lack of commitment?

- Is the hospital administrator involved in the process? By design or default? The administrator should at least express his/her views concerning the qualities or skills.

- The hospital should have a strategic plan to help define the skills and leadership qualities needed by the officers and members - that is, the board composition should reflect what the hospital is trying to accomplish.

4.0 WHO ARE THESE BOARD MEMBERS?

- Those who are entrusted to protect the public's interest, ensuring that the hospital is serving the community healthcare needs

- It is important to appoint trustees with the right knowledge, skills and experience, time, and inclination to serve.

- Board members should be tempered by the realities of the issues facing the organization and the types of expertise required to address them

5.0 HOW IS THE BOARD OF TRUSTEES ORGANIZED?

- **Board Chairman**
- **Vice Chairman**
- **Secretary**
- **Treasurer**
- **Other Members**

- **Committees – cannot and should not do the work of the full board**

  It's up to the board to ensure that they function effectively

  - **Standing Committees – should reflect those responsibilities the board must fulfill – enhancing the effectiveness and efficiency of the full board when it meets**

- ✓ **Executive**
- ✓ **Budget and Finance**
- ✓ **Medical Staff Affairs**
- ✓ **Quality Improvement**
- ✓ **Strategic Planning**

- **Ad Hoc Committees– should be formed only when standing committees are not an appropriate mechanism for addressing a particular issue – having a very specific charge and be disbanded when their task is completed**

  - ✓ **Building**
  - ✓ **Disaster Planning/Preparedness, Etc.**

"COMMITTEES ARE THE WORK HORSES OF THE BOARD"

- **A healthy board delegates primary consideration of major concerns and issues to the appropriate committee, seeking guidance and direction from it.**

- **When a good committee structure is in place, board functions and responsibilities are distributed equitably among its members and the board is positioned to maximize its effectiveness.**

- **Properly structured and well-functioning committees are an asset; Poor ones waste valuable time and deflect, or even subvert, board attention and energy.**

6. HOW IS THE BOARD OF TRUSTEES ORGANIZED?

<u>RESPONSIBILITIES OF THE CHAIRMAN:</u>

- ♦ **Setting meeting schedules and overseeing preparation of meeting materials**

- ♦ **Presiding over board meetings**

- ♦ **Overseeing all committees**

- **Maintaining board policy and other resource manuals**
- **Ensuring effective recruitment, orientation, and development of board members**
- **Providing for regular board and individual trustee self-evaluation**
- **Planning for leadership succession**

THE BOARD CHAIRMAN CAN NOT:

- **Override decisions of the board**
- **Manage the daily operations of the hospital**
- **Make independent decisions regarding policy, goals, long range planning**
- **Unduly influence board members**

7.0 OTHER ROLES:

Vice Chairman- Assumes chairman's role if he is unavailable or unable to serve

Secretary - Keeps accurate records of board meetings, attendance, decisions, long range plans and goals, and policies

Treasurer- Oversees board related expenditures; may chair budget / finance committee

8.0 WHAT DOES THE BOARD D O?

To govern effectively, boards must perform certain roles and fulfill certain responsibilities-

- **Roles are the "HOW" aspect of governance** - activities boards must undertake to fulfill their responsibilities
- **Responsibilities are the "WHAT" aspects of governance** - specific matters to which boards must attend

8.1 CORE ROLES – Must execute to fulfill their responsibilities:

- **Policy formulation – direction and expectations of management and medical staff**
- **Decision making - based on policy**
- **Oversight - ensures accountability, i.e., monitoring, assessment, and feedback**

8.2 CORE RESPONSIBILITIES

- **Setting the direction – formulating mission, vision, and key goals**
- **Ensuring high levels of executive management performance**
- **Achieving quality goals – ensuring the quality of patient care**
- **Ensuring the hospital's financial health – protecting and enhancing resources**
- **Assume responsibility for itself – its own effective and efficient performance**

<u>To be effective a board must understand the "things" it must be doing – the right things, the right way, and at the right time</u>

An understanding of these responsibilities highlights their importance and calls for a proactive, informed, and effective governing board.

Someone will fulfill these responsibilities in all of our communities because they are essential for the success of any organization and they deal with a vital public service for the community. It is

highly desirable that these responsibilities continue to be carried out by community-based voluntary leaders.

While boards assume ultimate accountability, boards have no ability to perform the actual work of their organizations. They must see to it that such work is done by delegating tasks and authority to management and medical staff.

Management and the medical staff are, in turn, directly accountable to the board for their decisions and actions.

CORE "ROLES" OF THE BOARD

1.0 POLICY FORMULATION

- **Policies– statements of intent that guide and constrain further decision making and action and limit subsequent choices**
- **Primary mechanism through which boards influence their organizations**
- **Boards formulate policy with respect to each of their five responsibilities – policies flow directly from statements of responsibility**
- **Policies provide organizations with direction and are the means by which authority and tasks are delegated to management and the medical staff.**

2.0 DECISION-MAKING

- **Retain authority – for example, responsibility for its own performance**
- **Delegate authority – to management or medical staff (specified by policy)- i.e., allow decisions given certain limits– e.g., purchase decisions up to ---- w/o board approval – there is oversight (budget)**
- **Management or medical staff can be directed to forward recommendations that serve as the basis for a board decision**

3.0 OVERSIGHT

- **Monitoring – delegated tasks and authority are being executed and meet expectations**
- **Assessment - as above**

- **Feedback – information needed to modify existing policies and formulate new ones-**

  The board must put into place a governance information system (info designed for board)

CORE "RESPONSIBILITIES" OF THE BOARD

1. SETTING THE DIRECTION - ENVISIONING AND FORMULATING ORGANIZATIONAL ENDS

- Trustees working in partnership with management, involves the development and implementation of-
  - ✓ a compelling ***vision*** (attributes and characteristics desired for the future),
  - ✓ an unambiguous ***mission*** (purpose), and
  - ✓ a measurable ***action plan***.

The important tools of direction setting - vision, mission, strategies, and action plans cannot be developed and implemented effectively without an informed board that is involved cooperatively and continuously with executive management, and that is rooted in the needs and expectations of the community being served. All other board responsibilities flow from, and depend on, the fulfillment of this one.

2. ASSURING EFFECTIVE MANAGEMENT

- Appointing, supporting, and evaluating the performance of the Administrator
- Approving an appropriate organization and management structure, bylaws, policies
- Putting into place a plan for management development and succession

It's clear that these important activities require:

- a collaborative and active relationship with management
- a significant time commitment
- and a commitment that accountability for performance centers on mutually agreed-upon measures of personal and organizational achievements

- It is also imperative that the administrator has the skills and resources to ensure:
    - that the trustees have in place an orientation program for new members,
    - ongoing educational opportunities, and
    - a board performance self-evaluation process.

3. ENHANCING THE ASSETS

- Assets include:

✓ financial
✓ human
✓ facilities
✓ reputation

Fiduciary responsibilities of a board, enabled by the community to provide such essential services as health, are rooted in the financial performance of the organization. The board must pay equal attention to the good name and reputation of the organization, as well as the interests and needs of all those who serve as direct caregivers, support staff, and volunteers

4. ACHIEVING QUALITY IMPROVEMENT GOALS

- Meeting contemporary standards
- Rendering clinically appropriate care
- Achieving high levels of satisfaction by the community, the patients and their families

Maintaining an environment of continuous improvement for all elements of service is involved in this set of trustee responsibilities. Trustees, therefore, need to be

- knowledgeable about the state of the art of all such elements of quality
- must develop the information that is needed to maintain an environment of improvement in order to
- provide necessary oversight
- achieve understanding with those responsible for delivering the service to the community.

5. ASSUME RESPONSIBILITY FOR ITSELF

- Appropriate configuration
- board size and composition
- member terms
- board budget and staffing
- officers, and committees
- recruitment, selection, and orientation for new members, and
- board performance evaluation

ALSO IMPORTANT:

6. ACTING AS A STAKEHOLDER ON BEHALF OF THE COMMUNITY BEING SERVED

- Develop an understanding of the true needs and expectations of its key stakeholders- strategies implemented by the hospital can be both responsive and practical

- Recognize and balance the true needs of the community with the self-interest or priorities of the organization

As Board members, leaders can clearly focus on:

- ensuring access to needed care for all,

- improving the health status of those served, and
- in moderating costs for the individual, the payment source, and the community-at-large.

The board, executive management, and the medical staff share interdependent leadership roles in guiding hospitals to assume a broader responsibility and accountability for the health status of the community.

CUSTOMER EXPECTATIONS -- Patients, Physicians, and Payers

- **Access to healthcare services**

- **Good clinical outcomes**

- **Reasonable costs**

- **Customer friendly service**

WHAT DOES THE BOARD DO?

- **Establishes and Reviews the Vision and Mission**
- **Establishes and Reviews the Board Bylaws**
- **Establishes and Reviews Board Policy**
- **Selects, Oversees, and Evaluates the Administrator**
- **Approves and Regularly Reviews the Strategic Plan**
- **Appoints and Reviews Performance of Medical Staff**
- **Establishes and Regularly Reviews Annual Budget and Financial Performance**
- **Regularly Assesses Hospital Operational Performance**

NOTE: EACH ABOVE BULLET ITEM FOLLOWS ON AN INDIVIDUAL PAGE

WHAT DOES THE BOARD DO?

♦ Establishes and Reviews the Vision and Mission

VISION - ***The attributes and characteristics desired for the future***

(Example)

"Because of our high quality care and attention to the needs of our patients, Coast Provincial General Hospital will be the hospital of choice for the citizens of Mombasa and Coast Province"

MISSION - ***A broad general statement that describes the purpose, role and scope of the hospital***

Elements of a Mission Statement:

- **Basic Purpose**
- **Geographic Scope**
- **Commitment to Community Health**
- **Financial Viability**
- **Quality Commitment**
- **Support for Employees**
- **Support for Physicians**
- **Support for those unable to pay**
- **Linkage with Community Groups**
- **Involvement in Education and Research**

WHAT DOES THE BOARD DO?

♦ Establishes and reviews the board's bylaws

✓ **Number of Board members, qualifications, selection process**

✓ **Duties and Responsibilities**

✓ **Description of Officers and Roles**

- ✓ **Structure of Board and Board Committees**
- ✓ **Role of Executive Committee, if established**
- ✓ **Terms of Office, Officers and Members**
- ✓ **Time and Place of Meetings and Notice**
- ✓ **Quorum Definition**

WHAT DOES THE BOARD DO?

- ♦ **Establishes and Reviews Board Policy**
  - ✓ **Determines the need for policy creation**
  - ✓ **Establishes Policy**
  - ✓ **Identifies Implementation Responsibility**
  - ✓ **Reviews and Revises Policy as Necessary**

WHAT DOES THE BOARD DO?

- **Selects, Oversees, and Evaluates the Administrator**

✓ **Develop Job Description**

✓ **Recruit / Select Administrator**

✓ **Develop Goals and Objectives**

✓ **Develop Job Appraisal Content and Process**

✓ **Establish Compensation Package**

✓ **Delegate**

✓ **Delegate**

✓ **Delegate**

The Board should be at the vision, mission and objectives level, not spending time on operations. In other words, they should be steering the boat, not rowing it.

WHAT DOES THE BOARD DO?

- **Approves and Regularly Reviews the Strategic Plan**

- ✓ **Establishes Strategic Planning Committee**
- ✓ **Establishes Strategic Planning Process**
- ✓ **Approves Strategic Plan**
- ✓ **Reviews Implementation Progress and Accomplishments**
- ✓ **Approves Plan Revisions as Necessary**

WHAT DOES THE BOARD DO?

♦ **Appoints and Reviews Performance of the Medical Staff**

In collaboration with the Medical Staff:

- ✓ **Establishes a Procedure for Credentialing**
- ✓ **Establishes a Procedure for Delineating Clinical Privileges**
- ✓ **Establishes a Process for Periodic Reappraisal and Reappointment**
- ✓ **Links Medical Staff Appointments with Overall Hospital Quality Improvement Program**

WHAT DOES THE BOARD DO?

♦ **Establishes and Regularly Reviews Annual Budget and Financial Performance**

- ✓ **Reviews and Approves Budget Submitted by Administrator**
- ✓ **Receives and Reviews Periodic Financial Performance Reports**

Indicators:

- **Performance to budget- variances explained**
- **Operating margin-**

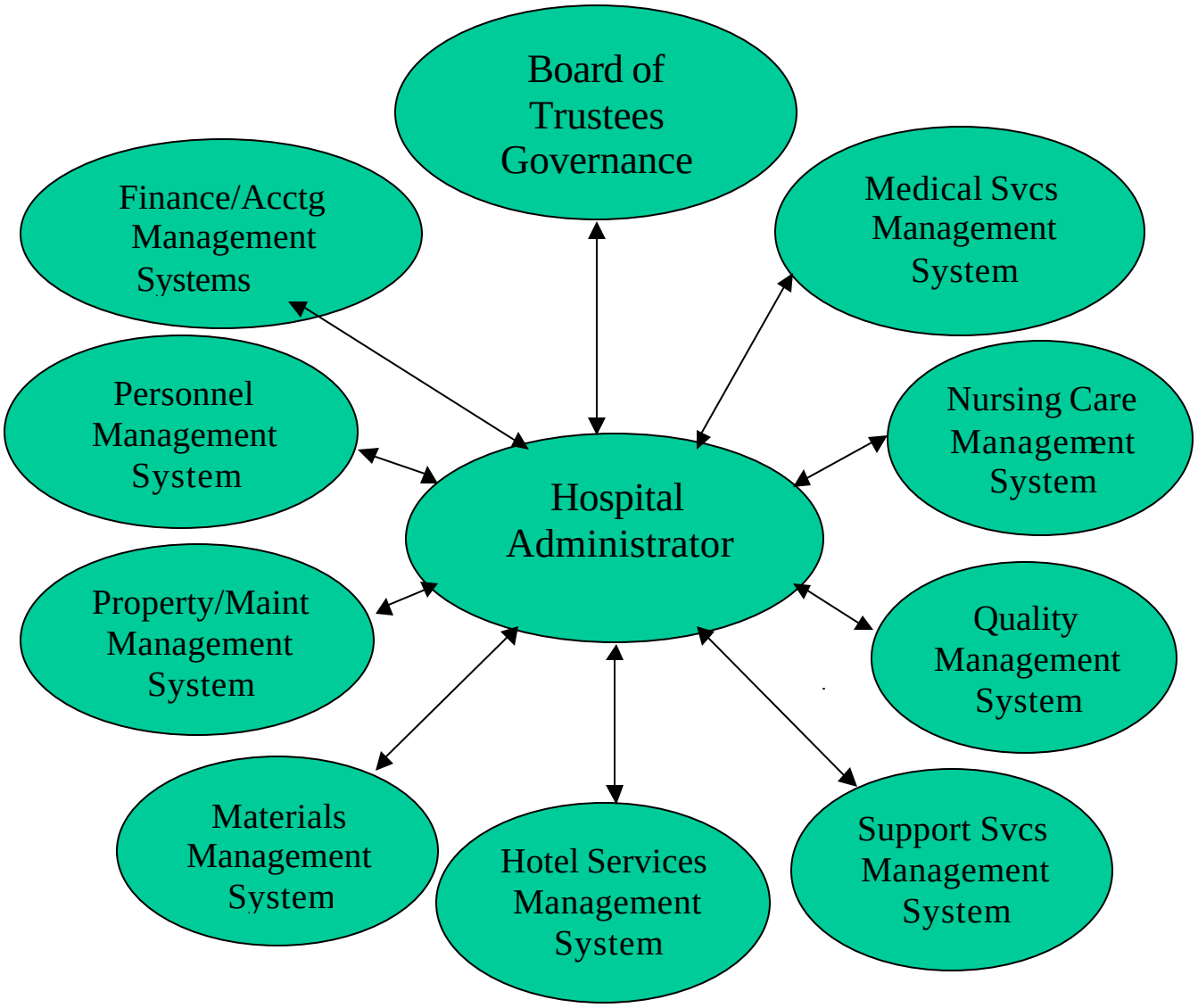
- **Ratio of free care**
- **Ratio of salaries to costs and revenue**

WHAT DOES THE BOARD DO?

♦ **Regularly Assesses Hospital Operational Performance:**

- ✓ **Hospital Organization Chart**
- ✓ **Hospital Scope of Services**
- ✓ **Hospital Staffing**
- ✓ **Quality of Care / Services**
- ✓ **Potential Conflicts of Interest**
- ✓ **Service Delivery: Performance Indicators**
  - ♦ **Number of Patient Admissions**
  - ♦ **Occupancy Rate (%)**
  - ♦ **Length of Stay**
  - ♦ **Number of Inpatient Surgeries**
  - ♦ **Number of Newborns**
  - ♦ **Number of Patient Deaths**
  - ♦ **Number of Outpatient Visits**

HOSPITAL PERFORMANCE REPORTING SYSTEMS



ROLES AND FUNCTIONS
OF THE
HOSPITAL ADMINISTRATOR AND THE
ORGANIZED MEDICAL STAFF

The role of the hospital trustee has been described, however, many decisions and activities in the hospital involve two other groups: the hospital administrator and the organized medical staff. The roles they play are described below.

THE HOSPITAL ADMINISTRATOR

1. Develops and maintains programs that implement board authorized goals and policies.

2. To develop and, with board approval, implement an organizational staffing plan for hospital operations (e.g., specify limits of authority delegated to employees).

3. Act as liaison to the community and other health care institutions.

4. To coordinate and facilitate appropriate interaction and communication among the various groups working at the hospital (e.g., ensure that the board and medical staff are communicating appropriately).

5. To develop and implement evaluation procedures for all functional areas / units of the hospital (e.g., analyze and report the costs per unit of laboratory tests)

6. To safeguard and ensure appropriate use of hospital resources (e.g., report to the board on hospital performance as shown by the operating budget)

THE ORGANIZED MEDICAL STAFF

1. To implement policies and procedures designed to provide patients with the best possible medical care within the hospital's available resources.

2. To recommend medical staff appointments and clinical privileges in order to provide a balanced and competent medical staff.

3. To develop and implement a quality assurance mechanism, including peer review of the process and the clinical outcomes of care.

4. To provide continuing medical education for its members.

5. To develop an organizational structure that will enable the medical staff to relate to the board and to govern itself.

RELATIONSHIPS AND EXPECTATIONS OF THE BOARD, HOSPITAL ADMINISTRATOR, AND PHYSICIANS

Hospitals are among the most complex organizations to manage. This complexity is due in part to the "management of interpersonal relations".

THE BOARD'S EXPECTATION OF THE ADMINISTRATOR

The board's principle expectation of the administrator is managing the hospital with considerable skill and diplomacy, particularly with regard to the quality of care provided, and cost and complaint control.

Boards judge their administrator's success in terms of:

- ✓ A clean well maintained facility
- ✓ Modern equipment
- ✓ Good food, and most important,
- ✓ Lack of complaints on the part of the medical staff first, and patients second.

Boards also expect the administrator to project a favorable image of the hospital both within and outside its walls.

THE ADMINISTRATOR'S EXPECTATION OF THE BOARD

The administrator expects board members to be a source of:

- ✓ Information
- ✓ Direction
- ✓ Advice
- ✓ Counsel, and
- ✓ Guidance

This has been referred to as 'board oversight" – management, financial, quality, and strategic oversight.

The administrator also expects board members to provide information based on "feedback" from the community that yields valuable insight in the expectations, problems, or concerns of the general community.

AVOIDING BOARD-ADMINISTRATOR ROLE CONFLICT

- Most administrators would argue that the translation of board policy into operational strategies must be the responsibility of the administrator

- The administrator usually does not expect or desire the board to become involved in the administration of the hospital, other than to ensure it is consistent with board policy.

- When the action is required and consistent with board policy and direction, the administrator expects the board's support.

- The administrator expects the board to respect the role of the administrator by discouraging physicians and hospital staff from bringing their concerns directly to board members without consulting the administrator.

The most common source of role ambiguity between the board and the administrator is the blurred line between policy development and administration.

THE ADMINISTRATOR'S EXPECTATIONS OF PHYSICIANS

The administrator expects the physician to:

- Assist with the control of costs

- Participate in the decision making process so they can understand and support tough decisions that must be made to allocate resources

- Complete their paperwork

- Attend meetings
- Participate in other activities that may not be in their direct interest

- To participate in quality improvement programs

- Maintain high quality medical care, and

- To treat hospital staff with respect and dignity because morale is largely dependent on their interaction with physicians

Ultimately, both of their livelihoods depend on the astute management of the hospital by the administrator.

PHYSICIANS' EXPECTATIONS OF THE ADMINISTRATOR

Physicians expect the Hospital Administrator to:

- Not interfere in their decisions concerning the provision of medical care
- Promote access to the facilities, equipment, supplies, and trained personnel
- Allow physicians to do all that they are trained and equipped to do
- Be the first informed of new hospital policy or decisions through personal and timely communication

Physicians understand that their reputation and that of the hospital are mutually dependent.

THE HOSPITAL LEADERSHIP TEAM

- THE GOVERNING BOARD
- THE HOSPITAL **MANAGEMENT**
- THE ORGANIZED **MEDICAL STAFF**

The more cohesive the leadership team, the greater the likelihood they will achieve the ultimate goal: To improve the health of the community and provide cost effective services in a quality – oriented manner.

5 KEY PESPONSIBILITIES

OF AN EFFECTIVE

LEADERSHIP TEAM

1. MAINTAINING GOOD INTERNAL AND EXTERNAL RELATIONSHIPS

Communication, Cooperation, and Compromise

2. RETHINKING THE ORGANIZATION'S MISSION AND ESTABLISHING GOALS AND OBJECTIVES

Ensuring the hospital's survival and improving the health status of the people it serves

3. ASSURING THE COMPETENCY OF THE GOVERNING BOARD, THE MEDICAL STAFF AND SENIOR MANAGEMENT

Establish a formal quality improvement process and ensure a sound medical staff credentialing process for granting privileges to qualified physicians

4. ENCOURAGING CONTINUING EDUCATION FOR BOARD MEMBERS, PHYSICIANS AND EMPLOYEES

5. EFFICIENTLY USING RESOURCES TO MEET THE COMMUNITY'S MOST IMPORTANT HEALTH NEEDS IN AN ECONOMICALLY EFFICIENT, QUALITY-ORIENTED MANNER

- Realize the hospital can not be all things to all people
- Requires an ongoing assessment of community needs
- Re establish the hospital's priorities and allocate its financial and human resources wisely

THE HOSPITAL AS A COMMUNITY ORGANIZATION

The relationship between a hospital and the community it services is a major determinant of the hospital's effectiveness. The board must assist in the assessment of community needs and must see that the hospital addresses the health problems in the community by offering appropriate services. It is important to understand that maintaining a relationship that is mutually beneficial is an ongoing process.

Establishing a strong and lasting relationship with the community can come about only with the involvement and participation of all three—the board, the hospital administrator, and the medical staff

FIVE STEPS IN RELATING TO THE COMMUNITY

The five steps the board needs to consider in the process of identifying and meeting community health care needs:

1. **Identify and define the community. What is the community being served by your hospital? This is one of the elements required in any hospital strategic plan.**

    - **What is the demographic profile of your community in terms of- population size? Level of income? population over 55?**
    - **What is the community profile expected to be 5 -years from now?**

2. **What other health care providers are serving your community?**

3. **Identify community health care needs.**

4. **Determine the hospital's role in meeting community health care needs.**

5. **Find out community attitudes about health care services –**

    - **A community advisory committee can provide both a forum for the community to express itself to the hospital and a sounding board for the hospital to gauge community reaction to proposed hospital actions. Community surveys can be helpful to learn opinions**

Most Board members understand that the hospital's services should reflect the community's health care needs. Less clear, however, is how to define that community, how to assess it's health care needs, and how to ensure that the hospital is meeting those needs.

PREVENTING BOARD – COMMUNITY DISCONNECT

THE SIGNS OF A BOARD/COMMUNITY DISCONNECT ARE NOT ALWAYS OBVIOUS

- **Review the board's mix – a lack of diversity of opinion**
- **Lack of turnover and/or introduction of new members**
- **Difficulty recruiting new members, or – current members are from the same subset in the community (all from the north side or from business sector, etc.)**
- **Poor attendance at board meetings**
- **The same agenda from meeting to meeting – dull meetings**
- **Members who fail to bring community ideas and issues to the table**
- **Boards that do not engage in self-evaluation, as both individual members and as a group**
- **Failing to respond to community needs with the appropriate programs and services**
- **Declining community health outcomes, or financial performance, or marked payer, employer, or patient dissatisfaction**

MAINTAINING A FRESH PERSPECTIVE OF THE BOARD

- **Set term limits**
- **Appoint regional advisory councils – people who live in the community to keep the board updated- what is going on, especially in population clusters**
- **Use a self-evaluation process to determine board effectiveness**
- **Conduct individual self-evaluations – number of meetings attended, quality and frequency of participation, whether their contributions warrant their membership**
- **Develop meaningful board selection criteria – often, it's about looking for people in the community with a broader public health view, a broader vision of what's best for everybody**

MAINTAINING BOARD MOMENTUM: WARNING SIGNALS OF BOARD DISTRESS

1. **Board is unwilling to discuss potentially difficult issues as a group- or board members are forming private cliques to debate such issues**

2. **The Board seeks additional information or a second opinion on an important matter without the involvement of the Administrator**

3. **The Board spends more time discussing how things were done in the past than planning for the future**

4. **The Board ignores its own bylaws, notably by exempting itself from term limits**

5. **Similar agendas from one meeting to the next**

6. **Failing to involve physicians and nurses in discussions**

7. **Weighing down the board with "outside experts"**

Being sensitive to any of these changes in board dynamics may help to avert serious conflicts and keep the board focused on what is best for the organization in the long term.

FOUR MAJOR CHALLENGES

FACING COMMUNITY-BASED BOARD MEMBERS:

1) **RECRUITMENT, DEVELOPMENT, AND RETENTION OF QUALIFIED MEMBERS**

2) **MEETING KNOWLEDGE REQUIREMENTS**

3) **DEVELOPING EFFECTIVE GOVERNANCE INFORMATION SYSTEMS**

4) **ACHIEVING INTEGRATED COMMUNITY HEALTHCARE SYSTEMS**

NOTE: EACH POINT FOLLOWS ON A SINGLE PAGE

FOUR MAJOR CHALLENGES

1) RECRUITMENT, DEVELOPMENT, AND RETENTION OF QUALIFIED BOARD MEMBERS:

- AN INFORMED, EDUCATED, AND ENTHUSIASTIC BOARD WILL STRENGTHEN THE ORGANIZATION.

- THE HOSPITAL SHOULD HAVE A STRATEGIC PLAN THAT CAN BE USED TO HELP DEFINE THE SKILLS AND THE LEADERSHIP QUALITIES THAT ARE NEEDED BY THE GOVERNING BOARD MEMBERS.

- EACH MEMBER SHOULD BE ENCOURAGED TO ASSESS REALISTICALLY WHETHER BOARD SERVICE IS PRACTICAL FROM A **TIME AVAILABILITY** POINT OF VIEW AND BE PREPARED TO SUSTAIN SUCH A COMMITMENT FOR THE TERM OF THE APPOINTMENT.

- SOME GENERAL QUALIFICATIONS INCLUDE EXPERIENCE, CREDIBILITY IN THE COMMUNITY, COMMITMENT TO THE COMMUNITY, UNIQUE SKILLS, KNOWLEDGE OR PROFESSIONAL TRAINING, AND ABILITY TO COMMUNICATE EFFECTIVELY. ALSO, OTHER CONSIDERATIONS, SUCH AS REPRESENTATION OF MINORITY GROUPS OR GEOGRAPHIC AREAS, COULD BE USED IN SCREENING CANDIDATES.

- IT IS THE RESPONSIBILITY OF EXECUTIVE MANAGEMENT IN PARTNERSHIP WITH BOARD LEADERSHIP TO ENSURE THAT TIME SPENT BY THE MEMBER IS **MEANINGFUL AND PRODUCTIVE**. (Care in setting agendas, providing in advance pertinent information)

- **HISTORICALLY HOSPITALS HAVE GROWN AND FLOURISHED UN DER THE LEADERSHIP OF TALENTED AND COMMITED BOARD MEMBERS**

- THE HOSPITAL ADMINISTRATOR BENEFITS FROM A STRONG BOARD IN THAT ITS MEMBERS CAN PROVIDE LEADERSHIP AS WELL AS EXPERTISE IN MANY AREAS, THEREBY MAKING THE INSTITUTION MORE EFFECTIVE AND THE ADMINISTRATOR'S JOB MORE SATISFYING.

2) MEETING KNOWLEDGE REQUIREMENTS:

- FOR BOARDS TO BE EFFECTIVE IN FULFILLING THEIR CORE RESPONSIBILITIES, SUFFICIENT KNOWLEDGE ABOUT THE FIELDS OF HEALTHCARE DELIVERY AND FINANCE AND THE ISSUES FACING ORGANIZATIONS IS ESSENTIAL.

- WHAT IS REASONABLY EXPECTED - AND NEEDED – IS AN ONGOING PROGRAM OF INDIVIDUAL AND GROUP DEVELOPMENT THROUGH BOARD EDUCATIONAL PROGRAMS, EXPERIENCE INVOLVING THE WORK OF THE BOARD, AND SELECTED READINGS. AREAS OF KNOWLEDGE-BUILDING INCLUDE:

    - ETHICAL DECISION MAKING;
    - MANAGING FINANCIAL RISK;
    - QUALITY ASSESSMENT AND IMPROVEMENT;
    - STRATEGIC PLANNING AND P OSITIONING;
    - HEALTH STATUS MEASUREMENT; AND
    - ACHIEVING HEALTHY COMMUNITIES.

MAJOR CHALLENGES

3) DEVELOPING EFFECTIVE GOVERNANCE INFORMATION SYSTEMS

- TOO OFTEN BOARDS ARE PRESENTED WITH DATA DESIGNED PRIMARILY TO BE USED BY MANAGEMENT –
  - Operational in content – rarely strategic by intent

- USEFUL INFORMATION IS HIGHLY SELECTIVE– VALID– ACCURATE - TIMELY
  - Information regarding the most important things- policies and decisions

- COMPARATIVE INFORMATION-
  - The most meaningful and useful information has a high degree of contrast – portrayed across time and/or compared to similar information from other hospitals.
  - Such comparisons allow the board to put information into context and make meaningful evaluations

- CLEAR – CONCISE – USER-FRIENDLY INFORMATION
  - Presented in a simple manner, not wrapped in esoterica, jargon and technical minutiae

- **REACHING AGREEMENT ON A PREFERRED GOVERNANCE INFORMATION SYSTEM WILL IMPROVE THE HARMONY AND RELATIONSHIP BETWEEN THE BOARD AND MANAGEMENT, AND WILL HAVE THE POTENTIAL OF IMPROVING BOTH THE EFFECTIVENESS AND SATISFACTION OF THE BOARD.**

4) ACHIEVING INTEGRATED COMMUNITY HEALTHCARE SYSTEMS

GENERALLY INCLUDES 3 ELEMENTS:

- **BEING RESPONSIBLE FOR DELIVERING A COMPREHENSIVE SET OF SERVICES**

  - ✓ HEALTH PROMOTION AND DISEASE PREVENTION
  - ✓ MEDICAL CARE, INCLUDING AMBULATORY SETTINGS
  - ✓ EMERGENGY CARE

✓ ACUTE INPATIENT CARE

  - ✓ POSTACUTE, LONG-TERM, AND REHABILITATION
  - ✓ HOME HEALTH SERVICES

- **BEING PUBLICLY ACCOUNTABLE FOR THE PERFORMANCE OF THE ENTIRE ORGANIZATION–**

  - ✓ MEETING SPECIFIC ACCESS CRITERIA AND STANDARDS
  - ✓ MEETING CONTEMPORARY QUALITY STANDARDS
  - ✓ MEETING EFFICIENCY AND EFFECTIVENESS STANDARDS, INCLUDING FINANCIAL, AND ORGANIZATIONAL

- **BEING COLLABORATIVE PARTNERS WITH OTHER SEGMENTS OF THE COMMUNITY IN WORKING TOWARD ACHIEVING HEALTHIER COMMUNITIES**

SUMMARY:

"Experience suggests that Boards are often impaired because they are either unaware or unable to practice the fundamentals of governance, their ultimate responsibilities, and their core roles. To enhance their performance, improve their effectiveness, and make the contributions they could, Boards must have a precise, clear, and shared understanding of the type of work they could and should be doing— and then they must just do it". (Pointer and Ewell, 1985)

In this early phase of decentralization extraordinary leadership will be required from hospital boards and their paid hospital executives, working together and committed to a shared vision of the future for their hospital organization if significant progress is to be achieved.

Time, attention, priority, effort, and sustained commitment to improvement are in order for all.

The extent to which this evolving system of healthcare delivery for this Province and community is preserved and strengthened is at stake.

Thank you very much for your attention and participation. Good luck and best wishes for a long and successful tenure.

****

SELECTED REFERENCES

HOSPITAL BOARD AND MEDICAL STAFF RELATIONSHIPS

ALLOCATION OF DECISION-MAKING RESPONSIBILITIES

HOSPITAL BOARD MAKES ULTIMATE DECISION – NEITHER SOLELY – MEDICAL STAFF MAKES DECISION

No Duty to Consult- ***Singular***	**Informal Consultation-** Consultative	**Formal Consultation-** Shared	**Formal Consultation-** Joint	**Formal Consultation-** *Shared*	**Informal Consultation-** Consultative	**No Duty to Consult-** Singular
1. Bylaws	Discontinuance of a Service	Create New Department	Rule on Med. Staff Bylaws	Bioethics	Evaluate Transfers	Medical Policies
2. External Relations	External Relations, Med.	**Limit Procedures**	Select Medico-Admin. Officers	Personnel Use		Professional Evaluation of Quality of Care
3. Monitoring Quality	Hospital Services	Assign Staff Categories	Amend Bylaws Regarding New Categories	Physician Contracts - Patient Care Functions		Application of Utiliz. Mgt. Criteria
4. Enforcement of Sanctions	**Marketing**	Rule on Access of Non MDs	Rule on Closure of Med. Staff	Development of QA Plan		
5.	Hospital Diversification	Rule on Impaired Physicians	Rule on Limited Licensed Practitioners	Corrective Action		
6.	**Outreach**	Develop Hospital Rules/Regs	Rule on Credentials - Instit. & Prof			
7.	Mergers and Acquisitions	Perform Fiscal Planning	Implement QA Plan Update			
8.	Corporate Reorganization	Rule on Contracts with Third Parties	Enforce QA Plan			
9.		Rule on Physician Contracts - Admin.	Choose Utiliz. Mgt. Plan			
10.			Resolve Impasses			

HOSPITAL BOARD PROFILE

The first step in governance continuity is the need for a disciplined approach to recruiting and selecting new members as vacancies become available.

Effective recruitment first involves an analysis of the organization's current and ling-term needs. If gaps in member's abilities, special skills, or demographics become apparent after comparing the organization's needs with the current board's profile. Finding the right people should be given a greater priority than merely filling a vacancy.

BOARD PROFILE

Qualifications	Member	Member	Member	Member	Member	Member	Member	Member
Special expertise Needed								
Medical/Clinical								
Financial								
Legal								
Business Mgmt.								
Marketing/PR								
Government								
Other								
Other								
Community Relations								
Demonstrated Involvement								
Age								
Residence								
Male								
Female								

Other								
Board Tenure								
Years on Board								
Yrs/Mos. To Term								

A test of the board's success lies in its ability to use the diversity of its members to bring about the best possible policy decisions for the hospital.

NEW BOARD MEMBER CHECKLIST

If you want to be a good Board member, you must work at the job.

To perform competently as a Board member, you must quickly learn a great deal about the hospital and the board. The following checklist can assist you in becoming oriented to and informed about your new job.

1. Read a description of the services provided by the hospital and the educational program it provides.
2. Review the hospital bylaws and the medical staff bylaws, and examine the hospital's organizational structure.
3. Attend new member orientation session.
4. Ask for a tour of the hospital's physical facilities.
5. Meet key members of the administrative and medical staffs.
6. Read the history of the hospital, the long-range plan, and the board policies.
7. Familiarize yourself with the hospital's finances, its schedule of charges, and its sources of income.
8. Review a sample of patient care evaluation reports.
9. Review minutes of recent board meetings.
10. ASK QUESTIONS. Ask about anything you do not understand.

NEW BOARD MEMBER COMMITMENT

I Pledge:

1. To establish as a high priority my attendance at all meeting s of the board, committees and task forces on which I serve.
2. To come prepared to discuss the issues and business to be addressed at scheduled meetings, having read the agenda and all background material relevant to the topics at hand.
3. To work with and respect the opinions of my peers who serve this board, and to leave my personal prejudices out of all board discussions.
4. To always act for the good of the organization.
5. To represent this organization in a positive and supportive manner at all times and in all places.
6. To observe the parliamentary procedures and display courteous conduct in all board, committee and task force meetings.
7. To refrain from intruding on administrative issues that are the responsibility of management, except to monitor the results and prohibit methods that conflict with board policy.
8. To support in a positive manner all actions taken by the Board of Trustees even when I am in a minority position of such actions.
9. To avoid conflicts of interest between my position as a board member and my personal life. If such a conflict does arise, I will declare that conflict before the board and refrain from voting on matters in which I have conflict.
10. To agree to serve on at least one committee or task force, I will:
    a. call meetings as necessary until objectives are met;
    b. ensure that the agenda and support materials are delivered to all members in advance of the meetings;
    c. conduct the meetings in an orderly, fair, open and efficient manner;
    d. make committee progress reports/minutes to the board at its scheduled meetings, using the adopted format.
11. To participate in- 1)the annual strategic planning retreat, 2) board self-evaluation program, and 3) board development workshops, seminars, and other educational events that enhance my skills as a board member.

HOSPITAL GOVERNING BOARD

STATEMENT OF POLICY REGARDING "CONFLICTS OF INTEREST"

GENERAL

1. It is the policy of Coast Provincial General Hospital (hereinafter referred to as "Hospital"), that members of its Governing Board avoid any situation or activity that involves, or appears to involve, a conflict between the Members' personal interests, financial or otherwise, and the interests of the Hospital. The effectiveness of this policy is dependent upon each Member's objectivity and unbiased judgement. A Member must follow a strict rule of personal conduct to ensure those actual conflicts or the appearance of conflicts between a member's interests and those of the Hospital do not arise. Within this overall general policy are areas of specific prohibition discussed below.

2. This policy can be equally applicable to the Member's immediate family, and to any other persons closely associated with the Member who benefit or may benefit improperly from the Member's relationship with the Hospital.

AREAS OF SPECIFIC PROHIBITION

Prohibited conduct includes, but is not limited to, the following:

1. A Member shall not derive any personal gain or benefit, financial or otherwise, from the use of, or from the ability to obtain, confidential information concerning the Hospital that the Member may have learned by virtue of his membership on the Board. In addition, a Member shall not divulge confidential information to any other person, except as required by the ordinary discharge of the Member's duties.

2. A Member shall not purchase, trade, or otherwise acquire any real or personal property in anticipation of its sale to or use by the Hospital, or in possible competition with the Hospital.

3. A Member shall not invest in, be employed by, or otherwise acquire any interest in any other hospital, or in a nursing home, retirement home, extended care facility, pharmacy, or similar facilities.

4. A Member shall not serve as an officer, director or employee of any business organization, with or without remuneration, if serving in such capacity could conflict with the Hospital's interests or welfare. Likewise, a Member shall not be a consultant to any business organization under such circumstances.

5. A Member shall not have an interest in any business organization that provides, or seeks to provide, products, labor, or services of any kind to the Hospital or to a supplier of the Hospital, if the Member could in any way influence relations, negotiations, or dealings with such suppliers.

6. A Member shall not accept gifts of other than nominal value, entertainment, loans, forgiveness of indebtedness, discounts, commissions, or any other personal favor or thing of value from any individual or business organization- 1) doing or seeking to do business with the Hospital, 2) competing with the Hospital, or 3) in which the Hospital has a financial interest.

PROCEDURE

1. A Member shall promptly report in writing to the Chairman of the Board any possible conflict of interest involving such Member. Should the possible conflict of interest pertain to the Chairman of the Board, the Chairman shall promptly report the matter in writing to the Vice-Chairman of the Board.

2. The possible conflict of interest shall be considered promptly by the disinterested members of the Board. The interested Member shall absent himself/herself from that portion of the meeting during which the matter is considered, and shall abstain from any vote taken by the Board with respect to such matter. The determination made and the action taken by the Board shall be final.

I have read and agree to comply with the:

CERTIFICATE

1. Statement of Policy on Conflict of Interest.

2. To the best of my knowledge and belief, I am not involved in any activity and have no interests that conflict or suggest a conflict with the interests of the Hospital, except as follows (if none, so state):

3. I will promptly report any future situation that might involve or appear to involve any conflict between my personal interests and the interests of the Hospital.

_____

Hospital Board Member **Date**

BOARD MEETINGS

How to ... Run an Effective Board Meeting

The board chairperson is responsible for planning, organizing, and conducting board meetings. A well-run board meeting is productive and helps to maintain the enthusiasm and effectiveness of the other board members. To plan and run an effective board meeting, the chairperson should:

- **Provide adequate advance notice of the meeting.**
- **Prepare a realistic agenda and supporting documents and deliver them to board members one week before the meeting.**
- **Start and conclude the meeting promptly.**
- **Introduce any guests, observers, or new members.**
- **Be familiar with the items on the agenda.**
- **Introduce each agenda item and clarify the primary issues.**
- **Address action items first and items that require more discussion second.**
- **Stick to the agenda and do not get sidetracked on other issues.**
- **Use parliamentary rules of order, but be flexible to achieve a consensus.**
- **Delegate to the board committees responsibility for overseeing detailed, time-consuming work requiring investigation and analysis.**
- **Summarize the discussion on each point, identify the course of action, and assign responsibility for work.**
- **Write up the minutes of the meeting immediately afterwards and distribute them while the meeting is fresh in people's memories.**

MAKING GOOD USE OF YOUR VALUABLE TIME AT BOARD MEETINGS

1. Prepare for the meeting- Review reports, read literature that is distributed seven days in advance. Come to the meeting with questions and applicable ideas and solutions to issues.

2. Know the meeting dates and times and plan to attend all meetings. Arrive promptly and remain through the entire meeting.

3. Place priority issues on the Agenda first for discussion and resolution. Discuss routine items later if you have time.

4. Schedule the meeting for 90 minutes. Adjourn no later than 2 hours.

5. Break only for constructive reasons not to relax – time to think or cool off from heated debate.

6. Combine lunch with an educational program.

7. Meet on the fourth Thursday or Saturday, which gives Committees time to meet during the first three weeks of the month. The monthly financial report needs about three weeks to be finalized, and the accounts of the previous month are closed by the 15th day of the current month.

8. Use Executive committee only if absolutely needed. It is not a convenient substitute for Board meetings.

9. Refer topics that require lengthy discussion to Committee.

10. Start – up standing committees:
    - **Executive**
    - **Finance**
    - **Medical Staff Affairs**

Later- after 6-months:

- **Planning**
- **Quality Improvement**
- **Building**

- **Disaster Planning/Preparedness**

SAMPLE BOARD MINUTES

HOSPITAL BOARD OF TRUSTEES
MEETING
15 AUGUST 1998

PRESENT: Trustees- Mr. Xxx, Chm., Mrs. Yyy, Mr. Xxx, etc
Administration- Dr. Xxx, Mr. Xxx
Other- Dr. Xxx, Med. Staff Chm.

1. CALL TO ORDER: Quorum count

2. PREVIOUS MEETING MINUTES: Read and Approved

3. OLD BUSINESS: DISCUSSION / ACTION

3.1 Final Review/Approval of Operating Budget
3.2 Review of Board Bylaws

4. COMMITTEE REPORTS:

4.1 Finance-
4.2 Planning-

5. MEDICAL STAFF REPORTS:

5.1 Recommendation for new staff appointment

6. HOSPITAL ADMINISTRATOR REPORT:

6.1 Report of Quality Improvement Activity
6.2 Introduce new Hospital Matron
6.3 Review of Operating Budget

7. NEW BUSINESS:

7.1 Communication from Provincial Medical Officer

8. ADJOURNMENT:

PREVENTING BOARD – COMMUNITY DISCONNECT

THE SIGNS OF A BOARD/COMMUNITY DISCONNECT ARE NOT ALWAYS OBVIOUS

- **Review the board's mix – a lack of diversity of opinion**
- **Lack of turnover and/or introduction of new members**
- **Difficulty recruiting new members, or – current members are from the same subset in the community (all from the north side or from business sector, etc.)**
- **Poor attendance at board meetings**
- **The same agenda from meeting to meeting – dull meetings**
- **Members who fail to bring community ideas and issues to the table**
- **Boards that do not engage in self-evaluation, as both individual members and as a group**
- **Outreach efforts that are consistently met with a lack of enthusiasm, resentment, or outcry**
- **from the community**
- **Boards that fail to initiate new partnerships or respond to community needs with the appropriate programs and services**
- **Failing to respond to community needs with the appropriate programs and services**
- **Declining community health outcomes, or financial performance, or marked payer,**
  employer, or patient dissatisfaction

Today, hospital boards need a logical attitude about how the organization can thrive in the community and a broader vision of what's best for everybody.

MODEL EMPLOYMENT AGREEMENT

FOR CEO/ADMINISTRATOR

Dear _____:

_____ Hospital desires to secure your services as Chief Executive Officer of the Hospital. It is understood that your duties shall be substantially the same as those of the Chief Executive Officer of a business corporation, subject to the bylaws of the Hospital and the policies of the Board.

For your services, the Hospital agrees to pay you your current salary and fringe benefits, (as outlined in our letter dated _____ from the Executive Compensations Committee) and such higher salary and additional benefits as are mutually agreed upon at an annual review of your compensation by the Executive Compensation Committee of the Board. Your salary will be paid in equal monthly installments of: _____.

The Board may, its discretion, terminate this Agreement (prior to its expiration date) by giving written notice to you. Upon such termination, all rights, duties and obligations of both parties shall cease, except that the Hospital shall continue to pay you your then monthly salary for a period of _____ months (including the month in which termination occurred) as an agreed upon termination payment. Such pay shall be made in all instances except in the event of intentional illegal conduct by you. During this period, you shall be required to come to the Hospital or to perform any duties for the Hospital, nor shall the fact that you seek, accepted and undertake other employment during this period affect such payments. Also, during this period , the Hospital agrees to keep your life, health and long term disability insurance fully in effect and provide you without placement services.

Should the Board, in its discretion, change your duties or authority so it can reasonably be found that you are no longer performing as the Chief Executive Officer or the hospital, you shall have the right, in your complete discretion, to terminate this agreement by written notice delivered to the Chairman of the Board. Upon such termination you shall be entitled to the termination benefits described in the proceeding paragraph. You may also terminate this agreement for any other reason, by giving written notice to the Chairman of the Board, but if you do all rights duties and obligations of both parties will cease and you will not be entitled to any termination benefits.

This agreement may be extended for a term beyond its original term by a letter to that effect exchange between the parties prior to the expiration date of this agreement.

(Name of Hospital)

BY: _____

(Chairman of the Board)

I accept the job offer contained
in the above letter.

_____ DATE: _____

Chief Executive Officer/Administrator

Annotations to CEO/Administrator's Contract

(Letter of Agreement)

Paragraph 1

This paragraph sets forth the basic terms of the contract. It should be noted however that the specific duties of the CEO are not spelled out in the contract itself. This is done for two reasons. First, since the CEO should be involved in virtually every area of hospital operations, he must not be limited by a "laundry list" of duties that narrowly circumscribe the scope of his responsibility. Such lists can relegate the CEO to the status of a "hired hand." In addition, since the duties of the CEO constantly change as the hospital changes, it is unwise to lock him and the hospital into a set routine from the start. The contract likens the CEO's role to that of a CEO in a business corporation to underscore the broad responsibility entrusted to him by the Board.

Paragraph 2

This paragraph sets forth the consideration given the CEO in return for his services. Experience has led us to the conclusion that it is best that the CEO's actual salary and benefits not be laid out in detail in the letter agreement. Rather, they should be set forth in a separate letter from the executive Compensation Committee of the Board to the CEO. This letter should be kept strictly confidential. All too often the CEO's salary and benefits will be used by dissident elements on the board or medical staff as a means of attacking the CEO. Although those benefits may be appropriate for the CEO of a company with a budget of tens or hundreds of millions of dollars, they will not be perceived as such by rank and file hospital employees or the news media. A separate document will minimize the risk that this sensitive information will fall into the wrong hands. Newly recruited CEOs should delete "your current" and insert the parenthetical phrase in the first sentence of the paragraph.

After each annual salary review, the CEO's salary will presumably increase. New salary levels should be contained in a letter to the CEO from the Board Chairman, which will become incorporated into the initial contract. The contract also permits the CEO to direct that a portion of his salary go into tax shelters as deferred income to the extent permitted by law.

Paragraph 3

This paragraph is commonly referred to as the termination clause. It is by far the most important part of the contract. In the event that a majority of the Board decides the service …..
CEO are no longer required, for whatever reason, the contract is termed …….. However, the CEO will still be entitled to a stated amount of salary even though he is no longer working for the hospital. Also, the CEO is group life and health insurance benefits continue. Outplacement services are also provided. Other benefits may continue as negotiated. The exact number of months of termination pay to which the CEO is entitled is of course the subject of negotiation. The figure determined upon should accurately reflect the risk and challenges of the position. The clause referring to the expiration date

is obviously only used if the contract is for a stated term. The purpose of this clause is to protect the CEO from threats of termination aimed at making him act in his position with unnecessary caution. It is in the interest of the Board, the hospital and the patients. The CEO must be able to exercise his authority to the fullest extent possible. He must also be able to make hard decisions without fear that his job may be in jeopardy simply because someone on the board or the medical staff dislike the choices he has made for reasons unrelated to the best interests of the hospital.

Paragraph 4

This paragraph is similar to Paragraph 3, except that it comes into play if the board substantially changes the duties of the CEO, either by appointing another officer with similar duties or restricting the authority of the existing CEO. This would be one way to avoid the applicability of the termination provisions of Paragraph 3. As in the case of Paragraph 3, the CEO in this case will be entitled to full salary plus group life and health insurance for the number of months specified in Paragraph 3.

Paragraph 5

This paragraph makes it simple for the hospital and the CEO to continue the agreement beyond its initial term by signing a simple letter agreement as an extension. The letter need only state that the initial contract has been extended for another specified period and set out the CEO's new salary: All of the initial provisions and benefits continue in force during the extension.

The execution of the contract should be authorized by the Board. It becomes effective when it is singed by the Chairman of the Board and accepted by the CEO or on some later date agreed upon by the parties. It should be filed along with other essential corporate documents, with a duplicate original given to the CEO. Needless to say, the terms of the contract should be treated as confidential.

HOSPITAL GOVERNING BOARD

ANNUAL JOB PERFORMANCE EVALUATION

OF THE
HOSPITAL ADMINISTRATOR

OBJECTIVE	**(CIRCLE ONE)**
1. Strategic plan kept up to date	**1 2 3 4 5**
2. Capital expenditure budget developed and met	**1 2 3 4 5**
3. Operating budget developed and met	**1 2 3 4 5**
4. Maintains budgeted staffing levels in each department	**1 2 3 4 5**
5. Maintains visible presence within organization	**1 2 3 4 5**
6. Maintains positive relationship with medical staff leadership	**1 2 3 4 5**
7. Identifies and evaluates new business opportunities	**1 2 3 4 5**
8. Implements approved projects of strategic plan	**1 2 3 4 5**
9. Project schedules are met	**1 2 3 4 5**
10. Keeps Board informed	**1 2 3 4 5**

_____ divided by 12 equals = _____
TOTAL POINTS EARNED Average Evaluation Score

Rating Key:

1 = Never
2 = Rarely
3 = Most of the Time
4 = Almost Always

Signatures:

Board Chairman:_____

5 = Always **Administrator:_____**

BOARD SELF-ASSESSMENT QUESTIONNAIRE

There are no "right" or "wrong" answers; your personal views are what is important. In order to ensure the anonymity of all responses, please do not put your name anywhere on the form. After you have completed all the items, please fold the form, insert into the envelope provided, and drop it in the mail. thank you.

1. This board takes regular steps to keep informed about important trends in the larger environment that might affect the organization.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
2. I have participated in board discussions about what we should do differently as a result of a mistake the board made.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
3. I have had conversations with other members of this board regarding common interests we share outside this organization.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
4. We have had ad hoc committees or task forces co-chaired by a staff member and a board member.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
5. I have been in board meetings where it seemed that the subtle ties of the issues we dealt with escaped the awareness of a number of the members	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
6. Our board explicitly examines the "downside" or possible pitfalls of any important decision it is about to make.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
7. Orientation programs for new board members specifically include a segment about the organization's history and traditions.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
8. This board is more involved in trying to put out fires than in preparing for the future.	Strong agree	
	Agree	
	Disagree	

	Strongly disagree	
9. The Board sets clear organizational priorities for the year ahead.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
10. An annual report on this board's activities is Prepared and distributed publicly.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
11. This board communicates its decisions to all those who are affected by them.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
12. At least once every two years, our board has a retreat or special session to examine our performance, how well we are doing as a board.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
13. Many of the issues that this board deals with seem to be separate tasks, unrelated to one another.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
14. In discussing key issues, it is not unusual for someone on the board to talk about what this organization stands for and how that is related to the matter at hand.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
15. Values are seldom discussed explicitly at our board meetings.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
16. If our board thinks that an important group or constituency is likely to disagree with an action we are considering, we will make sure we learn how they feel before we actually make the decision.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
17. Differences of opinion in board decisions are more often settled by vote than by more discussion.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
18. There are individuals on this board who are identified as responsible for maintaining channels of communication with specific	Strongly agree	
	Agree	
	Disagree	

key community leaders.	Strongly disagree	
19. This board delays action until an issue becomes urgent or critical.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
20. This board periodically sets aside time to learn more about important issues facing organizations like the one we govern.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
21. I can recall an occasion when the board acknowledge its responsibility for an ill-advised decision.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
22. This board has formed ad hoc committees or task forces that include staff as well as board members.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
23. This board is as attentive to how it reaches conclusions as it is to what is decided.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
24. The decisions of this board on one issue tend to influence what we do about other issues that come before us.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
25. Most people on this board tend to rely on observation and informal discussions to learn about their role and responsibilities.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
26. I find it easy to identify the key issues that this board faces.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
27. When faced with an important issue, the board often "brainstorms" and tries to generate a whole list of creative approaches or solutions to the problem.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
28.When a new member joins this board, we make sure that someone serves as a mentor to help this person learn the ropes.	Strongly agree	
	Agree	
	Disagree Strongly Disagree	

29 I have been in board meetings where explicit attention was given to the concerns of the community.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
30. I rarely disagree openly with other members in board meetings.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
31. I have participated in board discussions about the effectiveness of our performance.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
32. At our board meetings, there is at least as much dialogue among members as there is between members and administrators.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
33. When issues come before our board, they are seldom framed in a way that enables members to see the connections between the matter at hand and the organization's overall strategy.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
34. I have participated in discussions with new members about the roles and responsibilities of a board member.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
35. This board has made a key decision that I believe to be inconsistent with the mission of this organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
36. The leadership of this board typically goes out of its way to make sure that all members have same information on important issues.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
37. This board has adopted some explicit goals for itself distinct from the goals it has for the total organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	

38. The board often requests that a decision be postponed until further information can be obtained.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
39. The board periodically requests information on the morale of the professional staff.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
40. I have participated in board discussions about what we can learn from a mistake we have made.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
41. Our board meetings tend to focus more on current concerns than on preparing for the future.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
42. At least once a year, this board asks that the executive director articulate his/her vision for the organization's future and strategies to realize that vision.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
43. I have been present in board meetings where discussions of the history and mission of the organization were key factors in reaching a conclusion on a problem.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
44. I have never received feedback on my performance as a member of this board.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
45. It is apparent from the comments of some of our board members that they do not understand the mission of the organization very well.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
46. This board has on occasion evaded responsibility for some important issue facing the organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
47. Before reaching a decision on important issues, this board usually requests input from persons likely to be affected by the decision.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	

48. There have been occasions where the board itself has acted in ways inconsistent with the organization's deepest values.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
49. This board relies on the natural emergencies of leaders, rather than trying explicitly to cultivate future leaders for the board.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
50. This board often discusses where the organization should be headed five or more years into the future.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
51. New members are provided with a detailed explanation of this organization's mission when they join this board.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
52. This board does not allocate organization funds for the purpose of board education and development.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
53. Other board members have important information that I lack on key issues.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
54. Recommendations from the administration are usually accepted with little questioning in board meetings.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
55. At times this board has appeared unaware of the impact its decisions will have within our service community.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
56. Within the past year, this board has reviewed the organization's strategies for attaining its long-term goals.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
57. This board reviews the organization's mission at least once every five years.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
58. This board conducted an explicit examination of its roles and responsibilities.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	

59. I am able to speak my mind on key issues without fear that I will be ostracized by some members of this board.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
60. This board tries to avoid issues that are ambiguous and complicated.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
61. The administration rarely reports to the board on the concerns of those the organization serves.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
62. I have been in board meetings where the discussion focussed on identifying or overcoming the organization's weaknesses.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
63. One of the reasons I joined this board was that I believe strongly in the values of this organization.	Strong agree	
	Agree	
	Disagree	
	Strongly disagree	
64. This board does not organize special events in the lives of its members.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
65. The board faces many policy questions that do not have clear answers.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
66. The board discusses events and trends in the larger environment that may present specific opportunities for this organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
67. Former members of this board have participated in special events designed to convey to new members the organization's history and value.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
68. This board provides biographical information that helps members get to know one another better.	Strongly agree	
	Agree	
	Disagree	
	Strongly Disagree	

69. This board seeks information and advice from leaders of other similar organizations	Strongly Agree Agree Disagree Strongly Disagree	
70. This board makes explicit use of the long-range priorities of this organization in dealing with current issues.	Strongly agree	
	Agree	
	Disagree	
	Strongly Disagree	
71. This board understands the norms of the professionals working in this organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
72. Members of this board seldom attend social events sponsored by this organization.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	
73. More than half of this board's time is spent in discussions of issues of importance to the organization's long-range future.	Strongly agree	
	Agree	
	Disagree	
	Strongly disagree	

HOSPITAL GOVERNING BOARD

MODEL

BOARD BYLAWS

PURPOSE OF BOARD BYLAWS

Board bylaws usually spell out the legal position and general responsibility.

Board bylaws customarily discuss:

- Selection of Members
- Term of office
- Duties, roles, and responsibilities of the board
- Time and place of meetings
- Committee structure, time and place of meetings
- Role of the executive committee
- Procedures for submission and processing of medical staff applications
- Procedures for appointing the administrator
- General policy requirements

BOARD BYLAWS

ARTICLE I

PURPOSE AND MISSION

The hospital shall strive to provide a scope of medical care that includes hospital inpatient and outpatient services and related services for promotion, prevention, diagnostic, therapeutic, rehabilitative, and health education services to citizens of the Coast Province and Kenya in general. The hospital shall strive to maintain linkages to the community(s) it serves in an effort to meet the health care needs and provide a high standard of medical services.

ARTICLE II

1. General Powers, Duties and Responsibilities.

1.1 The governing body of the hospital shall be its Governing Board (the Board). All of the hospital's power shall be exercised by or under the authority of the Board, and the assets, affairs and business of the hospital shall be managed under the direction of the Board, subject to the limitations set forth in the Gazetted Legal Notice 162 The Board must execute three roles in order to fulfill their responsibilities:

- policy formulation
- decision making
- oversight

1.2 The Board has the ultimate authority and responsibility for patient care and the overall quality of service in the hospital. The "Board authority" derives from the Ministry of Health and the hospital organization itself; therefore, the Board is accountable to both for its policies and performance

1.3 In general, the Board has the authority, duty and responsibility to direct the hospital management to accomplish its purposes. In fulfilling this role, the Board directly or through its medical staff, committees, officers and agents, is charged with specific duties and responsibilities detailed in these Bylaws.

1.4 The Board has the responsibility for organizing itself effectively, for establishing and following the policies and procedures necessary to

discharge its responsibilities, and for adopting bylaws in accordance with these requirements.

ARTICLE II continued…

1.5 The Board shall evaluate the performance of its committees, individual trustees, and its own performance as a whole

1.6 The Board's authority provides for conflict resolution

1.6.1 The hospital has a system for resolving conflicts among leaders and the individuals under their leadership. The system's effectiveness is reviewed regularly and revised as necessary.

ARTICLE III

1. <u>Specific Duties/Responsibilities/Obligations of Board Members</u>.

1.1 Appoints and reviews the performance of the hospital administrator, who is responsible for the management duties of the institution

1.1.1 The Board has the responsibility for selecting a qualified administrator and for delegating to the administrator the necessary authority to manage the hospital effectively.

1.1.1 The Board shall develop a written job description that delineates the duties and role of the administrator, particularly the administrator's organizational relationship with the Board. The Board shall formalize this relationship through a contractual agreement.

1.1.2 The administrator is the representative of the Board and has the primary responsibility for all matters affecting the institution.

1.1.3 The Board shall establish a mechanism for the regular evaluation of the administrator. Such an evaluation shall provide guidance, support, and facilitate ongoing communication between the Board and its primary representative

1.2 The Board has the authority and responsibility for ensuring proper organization of the hospital's medical staff and for monitoring the quality of medical care provided under the auspices of the institution

1.2.1 The Board approves or disapproves all medical staff appointments and delineates clinical privileges, approves the medical staff's organization and bylaws, and provides the staff support and resources necessary to enable the medical staff to fulfill its role

1.2.2 The Board is responsible for the quality of patient care provided by the institution through the quality assessment program, which may include results of medical care evaluation studies and resource utilization review programs for appropriateness. Although it

delegates responsibility to the organized medical staff pertaining to the quality of medical services, the Board retains certain responsibilities pertaining to the organization of the medical staff

ARTICLE III continued…

The Board:

1.3 Assists in the selection and orientation of new board members

1.3.1 To ensure continuity, the Board should establish a system for orderly membership selection.

1.3.2 The Board should establish an orientation program for new Board members and continuing education programs to keep members current on key issues.

1.4 Assures that the Board is broadly representative of the community the hospital serves

1.5 Members maintain active participation in Board activities, including regular attendance at general sessions and special committees

1.7 Identifies potential conflicts of interests which are noted in the Board's official record

1.6.1 The Board shall adopt, and may amend from time to time, policies and procedures for officers and employees governing conflicts of interests so that such conflicts may be avoided or fully disclosed.

1.7 Participates in the financial and short and long range planning of the institution

1.7.1 The Board has responsibility and authority, subject to Ministry of Health review, for determining the hospital's mission, and for establishing a strategic plan, goals, objectives, and policies to achieve that mission

1.7.2 The Board, with consideration for community needs and working with the hospital's executive management and medical staff, should develop a long-range plan.

1.8 Reviews the financial operation of the institution

1.8.1 The Board should ensure that adequate capital is available for the hospital's investment strategies and should routinely monitor intermediate and short-term operational fund balances.

1.8.2 The Board is entrusted with the resources of the hospital and with the proper development, utilization, and maintenance of those resources.

1.8.3 The resource management and allocation system should encompass long-range and short-range financial plans, performance evaluation against the plans, and regular financial reports to the Board.

ARTICLE III continued…

<u>The Board</u>:

1.9 Assesses the hospital's physical plant, personnel policies, and admissions practices

1.10 Reviews, through administrative reports, the performance of the institution, and it's programs to evaluate and improve the organization's performance, the quality of services provided, and the types and scope of services being offered.

1.11 Evaluates the services of the hospital to assure they meet patient needs and are in agreement with comprehensive planning needs

1.12 Evaluates hospital public relations activities

1.13 Delegates to the Medical Staff Procedures for Submission/ Processing Medical Staff Applications

1.14 Establishes the Procedure for Appointing a Hospital Administrator

1.15 Establishes External Relationships / Community Linkages, e.g.,

1.15.1 Dialog with patients in the community to ensure the appropriateness of the hospital's mission and goals and its ability to identify community healthcare needs

1.15.2 Communication with local business, industry, and professional and civic organizations, schools and social agencies.

1.15.3 Liaison with other health planning and health promotion organizations that **serve all or part of the same community.**

1.16 Ensures Development of Hospital Human Resources

1.16.1 The Board has the responsibility and authority for the organization, protection, and enhancement of the hospital's human resources. The quality of care provided by an institution is directly affected by the quality of its staff.

1.16.2 Although the Board delegates operational authority to management for the recruitment, selection, development and proper use of the hospital's human component, the Board shall be assured through management reports that an effort is made to keep abreast of the attitudes and concerns of staff regarding their work environment.

ARTICLE IV

1. Organization of the Board.

1.1 The structure and composition of the Board and the policies and procedures it follows to ensure the orderly conduct of its business are critical in fulfilling the institution's mission and goals to serve the community.

1.2 The composition of the Board is of great importance. The Minister of Health selects members upon considering recommendations from the current Board and other community leaders.

1.3 Members are selected on the basis of ability to serve the hospital and community effectively, not to represent particular interests or groups. Leadership characteristics, such as professional expertise, demonstrated community leadership and active participation in other community organizations should be considered, as should personal and demographic characteristics in achieving a balanced Board.

1.4 To the extent feasible, Board members should reside or work in the hospital's service area.

2. The Selection of Board Members

2.1 There shall be from seven (7) to nine (9) trustees appointed to the Board by the Minister of Health

3. Board Member Term of Office.

3.1 The Board member shall hold office for three (3) years, and be eligible for reappointment

3.2 A member shall vacate his position on the Board in the following circumstances:

3.2.1 If a member is absent without reasonable explanation from not less than four (4) consecutive meetings of the Board

3.2.2 In the case of a member of a non-governmental organization, if he ceases to hold the office by virtue of which his nomination was made

3.2.3 If a member is convicted of a criminal offense

3.2.4 If a member ceases to reside or practice in the Province

3.2.5 If the Minister in his discretion resigns his appointment to the Board.

4. Officers of the Board.

4.1 Officers of the Board shall consist of the Chairman, Vice Chairman/Chairman-elect, Secretary and Treasurer

4.1.1 The Minister of Health shall appoint one member of the Board to be Chairman, and the board shall appoint from among its members, the Vice-Chairman, Secretary and Treasurer

ARTICLE V

1. Board Committee Structure.

1.1 Executive Committee

1.1.1 The Executive Committee shall consist of the Chairman, Vice Chairman, Secretary, Treasurer, and Chairman of the Board's Quality Assessment Committee. The hospital administrator and the director of clinical services shall be ex-officio members and should be present at all regular and special meetings. The chairman of the Board shall serve as committee chairman.

1.1.2 It shall be the duty of the executive committee to review and organize matters to be considered by the board, to make recommendations to the Board, and to serve as an advisory committee to the Board and administration

1.2 Finance Committee

1.2.1 Committee members shall consist of no less than five (5) persons, at least three (3) of whom shall be members of the Board. The treasurer of the board shall be chairman of the finance committee.

1.2.1 It shall be the duty of the finance committee to review the annual operating and capital budgets, to review the fiscal management of the hospital and its assets and to make recommendations relating thereto to the Board and to perform such other duties as may be assigned by the Board

1.3 Joint Conference Committee

1.3.1 Committee members shall consist of no less than nine (9) persons, three (3) of which shall be members of the Board, including the chairman who shall act as chairman of the committee, the hospital administrator, director of clinical services, three from the medical staff, and the hospital matron.

1.3.2 It shall be the duty of the joint conference committee to act as an advisory body on matters of policy, medical staff appointment, practices, and rules and regulations involving the management and professional services provided by the hospital.

1.4 Quality Assessment and Improvement Committee

1.4.1 Committee members shall consist of no less than nine (9) persons, three (3) of which shall be members of the Board, including the chairman who shall act as chairman of the committee, three (3) representing the medical staff, and three (3) from administration.

ARTICLE V continued…

1.4.2 It shall be the duty of the quality assessment and improvement committee to establish and maintain an effective hospital-wide quality improvement program, which is broad in scope and measures, assesses, and improves the performance of the organization and it's quality and appropriateness of services.

1.4.3 The committee shall review reports from the hospital quality assessment committee with recommendations for improvement where problems are identified.

1.5 Special and Ad Hoc Committees

1.5.1 The chairman of the Board may appoint special / ad hoc committees to assist the Board in the management of its responsibilities in the affairs of the hospital, naming the chairman of such committees and defining the assignment in each instance. Members of special/ad hoc committees need not be members of the Board. The tenure of each special/ad hoc committee shall be specified upon its appointment.

1.5.2 Special / Ad Hoc committees may include: building, disaster planning/preparedness, and Bylaws.

ARTICLE VI

1. Meetings of the Board.

1.6 The Regular Board Meetings:

1.6.1 The Board, as a whole, shall meet at least quarterly, in the hospital Board room, at a date and time agreed upon by members of the Board

1.6.2 The standing committees of the Board shall meet monthly

1.6.3 The administrator and director of clinical services shall be ex-officio members and should be present at all regular and special meetings.

1.6.4 Reports from Board committees, the director of clinical services and the administrator shall be reviewed

1.6.4.1 The director of clinical services report shall include recommendations for improvement where problems are identified.

1.6.4.2 The administrator's report shall include internal management reports that include patient utilization and financial management

ARTICLE VI continued…

1.7 Special Board Meetings

1.7.1 Special meetings of the Board may be called at any time by the chairman, the executive committee, or by petition of three (3) of the members

1.7.2 Sufficient notice of a special meeting shall be delivered to each Board member at least seventy-two (72) hours prior to the time set for the meeting, and stating the purpose of such a special meeting,

1.8 Attendance at Meetings.

1.8.1 Members are encouraged to attend all meetings of the Board. Participation in Board activities may be considered by the Minister of Health and Board chairman in evaluating members at the time of reappointment.

1.9 Quorum

1.9.1 The quorum requirement for all meetings of the Board is a majority of the members present

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ARTICLE VII

1. Medical Staff Organization

1.1 The hospital medical staff is responsible for the quality of medical and dental care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the Board, and that the best interests of the patient are protected by concerted effort. The physicians and dentists practicing in Coast Provincial General Hospital shall therefore organize themselves in conformity with medical staff bylaws, rules and regulations as adopted by the medical staff and approved by the Board.

1.2 Medical Staff Bylaws. The bylaws, rules and regulations shall be regularly/periodically reviewed to ensure consistency with the policies of the Board, current acceptable and prevailing standards, applicable legal and other requirements. The staff bylaws, rules and regulations may be amended from time to time by the staff subject to and effective upon Board approval.

2. Standards of Patient Care.

2.1 To achieve and maintain appropriate standards of patient care, the Board hereby establishes the following policies for its hospital services:

2.1.1 Only a member of the medical staff with admitting privileges shall admit patients to the hospital

2.1.2 Only practitioners with clinical privileges at this hospital, duly licensed by the Republic of Kenya, may be responsible for a patient's clinical diagnosis and treatment within the area of such practitioner's privileges

2.1.3 Each patient admitted to the hospital shall receive a base line history and physical examination by a member of the medical staff

2.1.4 Other direct medical care of patients provided by specified professional personnel shall be under the appropriate degree of supervision by a member of the medical staff

2.1.5 When a member of the medical staff requests permission to delegate or refer the performance of certain practices related to medicine or dentistry to specified professional personnel not employed by the hospital, those personnel must be credentialed.

ARTICLE VIII

1. Bylaws Amendments.

1.1 These bylaws may be amended or repealed and new bylaws may be made at any regular or special meeting of the Board by the affirmative vote of two-thirds of all the members of the Board. Notice of an amendment, including a copy thereof, shall be given to each member at least ten (10) days before the meeting at which the amendment is to be considered.

2. Periodic Review of Bylaws.

2.1 These bylaws shall be reviewed at least every two- (2) years by a special committee of the Board appointed for this purpose by the Chairman.

ARTICLE IX

1. BYLAWS ADOPTION.

Adopted by the Provincial General Hospital's Governing Board

_____
Date

_____
Chairman, Governing Board

_____
Vice-Chairman, Governing Board

_____
Secretary, Governing Board

H O S P I T A L

MEDICAL AND DENTAL STAFF

MODEL

STAFF BYLAWS

THE HOSPITAL MEDICAL AND DENTAL STAFF

MODEL BYLAWS

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical and dental care in the Hospital,

and must accept and assume this responsibility, subject to the ultimate authority of the Board of Trustees,

and that the best interests of the patient are protected by concerted effort,

the physicians and dentists practicing in the Coast Provincial General Hospital hereby organize themselves in conformity with the Bylaws, Rules and Regulations hereinafter stated.

DEFINITIONS:

No rule or regulation contained in this document shall be interpreted to be retroactive in terms of revoking privileges previously assigned to members of the Medical Staff without due process.

Wherever the term “Hospital” appears, it shall be interpreted to refer to Coast Provincial General Hospital.

Wherever the term “Administrator” appears, it shall mean the Chief Executive Officer of Coast Provincial General Hospital.

Wherever the term “Chief of Staff” appears, it shall also mean President of the Medical Staff.

Wherever the term “Medical Staff” appears, it shall be interpreted to refer to the Medical and Dental Staff, the formal organization of physicians and dentists who are privileged to admit and attend patients in the Hospital.

The term “Physician” shall mean a doctor of medicine legally qualified to practice medicine.

The term “Member” shall mean a physician or dentist duly appointed to the Medical and Dental Staff.

The term “Practitioner” shall be interpreted to mean physicians and dentists licensed/certified to practice their profession in Kenya.

ARTICLE I
NAME

The name of this organization shall be the “Medical and Dental Staff” of Coast Provincial General Hospital

ARTICLE II

PURPOSES and RESPONSIBILITIES

A. The purposes of this organization are:

1. to ensure that all patients admitted to the Hospital or treated as outpatients will receive the best possible quality and appropriateness of medical care;
2. to maintain a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and, through an ongoing review, an evaluation of each practitioner’s performance in the Hospital;
3. to provide a means whereby issues of a medico-administrative nature may be discussed by the Medical Staff with the Hospital Administrator, and the Hospital Board of Trustees;
4. to provide education and to maintain educational standards that will lead to continuous advancements in professional knowledge and skills; and
5. to initiate and maintain Bylaws, Rules and Regulations, and policies for the self-regulation and self-governance of the Medical Staff.

B. To effect the purposes stated above, the responsibilities of this organization are:

1. to provide continuous care for his/her patients; meet standards of professional performance and utilization established by the Medical Staff; abide by the Hospital and Medical and Dental Staff Bylaws, Rules and Regulations; appropriately document patient illness and care; assist the medical care evaluation and utilization programs; accept committee assignments; advise and supervise the less experienced; and accept advice and supervision from those more experienced

2. to evaluate practitioner's credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges that may be exercised by each individual practitioner in the Hospital
3. to evaluate practitioner and institutional performance through valid and reliable measurement systems, based when appropriate, on clinically sound criteria
4. Promoting the appropriate use of the medical and health care resources at the Hospital for meeting patient's needs consistent with sound health care resource practices

ARTICLE III

MEDICAL STAFF MEMBERSHIP

Membership to the Medical Staff of the Coast Provincial General Hospital is a privilege extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only members of the Coast Provincial General Hospital Medical Staff may utilize the Hospital and its resources.

THE HOSPITAL HAS A LEGAL DUTY AND MORAL OBLIGATION TO ITS PATIENTS FOR USING REASONABLE CARE IN SELECTING AND REVIEWING THE COMPETENCY OF PHYSICIANS AND DENTISTS ON ITS MEDICAL STAFF

A. Basic Qualifications for Membership:

1. Only physicians and dentists currently licensed/certified to practice their specialty who can document their background, experience, training and demonstrated current competence, their adherence to the ethics of their profession, their good reputation and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Hospital Board of Trustees that any patient treated by them in the Hospital will be given a high quality of medical care shall be qualified for membership on the Medical Staff.
2. No practitioner shall be entitled to membership or to exercise particular clinical privileges in the Hospital merely by virtue of the fact that he/she is licensed/certified to practice medicine or dentistry, that he/she is a member of a professional organization, or that he/she had in the past or presently such privileges at this or any other hospital.

B. Basic Responsibilities of Staff Membership:

1. Abide by the Medical Staff Bylaws, Rules and Regulations, and by all other established standards, policies and rules of the Hospital;

2. Provide patients with care in accordance with applicable and prevailing professional standards of practice;
3. Discharge such staff, department, committee and Hospital functions as responsible for by appointment, election or otherwise;
4. Prepare and complete in timely fashion the medical and required records for the patients he/she admits or in any way provides care to in the Hospital.

ARTICLE IV

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

A. The Application:

1. All applications for appointment to the Medical Staff shall be in writing, signed by the applicant, and submitted on the prescribed form to the Hospital Administrator. The application shall include:
   - 1.1 detailed information concerning the applicants professional qualifications, physical and mental health status, professional references, and must include documentation of completion of medical school and the approved residency training program in the specialty for which privileges are requested.
   - 1.2 The names of three (3) physicians who have had experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and ethical character.
2. The physician applicant shall have the burden of producing adequate information for proper evaluation of clinical competence, character, ethics, health status and other qualifications.
3. The application will include a statement by the applicant that he/she received and read the Hospital Medical and Dental Staff Bylaws, Rules and Regulations, and that he/she agrees to abide by them.
4. Applications for appointment to the Medical Staff will be considered only upon completion of the entire application and receipt of all reference information. The application will not be considered complete until necessary personal interviews with the applicant are held. By applying for appointment, each applicant thereby signifies his/her willingness to appear for interviews in regard to the application.
5. The physician applicant shall authorize Hospital representatives to obtain validation of information supplied and review relevant documents in support of the application.
6. The physician applicant shall release from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials.

7. The physician applicant shall release from liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information.
8. The application shall be presented to the Administrator for assembly of the necessary credentials and supporting documentation.
9. When the application has been deemed complete by the Hospital Administrator, the application with all supporting materials is forwarded to the appropriate clinical department and the staff credentials committee for evaluation and recommendation.

B. The Appointment Process:

1. Within 30 days of receiving the Chief of Department's recommendation, the Credentials Committee forwards the application and its report of investigation to the Medical Executive Committee. The report shall include a recommendation of appointment and staff category, clinical department and clinical privileges to be assigned and conditions of medical supervision.
2. Within 30 days the Medical Executive Committee forwards its recommendation to the Board of Trustees, which acts within 60 days of receiving the Medical Executive Committee's recommendation.
3. The Credentials Committee, Medical Executive Committee, or Board of Trustees may extend these time periods, respectively, if good cause exists and a statement of the reason for the extension of time is included in the appropriate minutes or other record of the matter.
4. When the Board of Trustees has approved an application, the Administrator shall transmit the decision to the applicant.
5. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within 30 days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.
6. When the recommendation of the Medical Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the Administrator shall promptly notify the applicant. The Board of Trustees shall take no action until the applicant has exercised or deemed to have waived his/her right to fair hearing as provided in these Bylaws. No right to a fair hearing arises, however, if the adverse recommendation results from failure of the applicant to provide adequate proof that he/she is licensed/certified as required by Medical Staff membership.
7. When the Board of Trustees' decision is adverse to the applicant in respect to either appointment or clinical privileges, the Administrator shall

promptly notify him/her of such adverse decision and such adverse decision shall be held in abeyance until the applicant exercises or has been deemed to have waived his/her rights according to the Fair Hearing Plan as provided in these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none exist.

8. When the Board of Trustees' decision is final, it shall send notice of such decision through the Hospital Administrator to the Chief of Staff, to the responsible Department Chief and to the applicant.

C. Reappraisal and Reappointment Process

The Staff Year is the Gregorian Calendar Year- 1 January through 31 December.

1. Reappraisal and Reappointment of all members of the Medical Staff shall be considered every other year in September.
2. At least 120 days prior to the scheduled reappointment date, the responsible Department Chief will provide the staff member with the reappointment application form. The completed form is to be returned to the Department Chief within 30 days. The Department Chief will review the member's performance information and reappointment request and forward to the Credentials Committee with his/her recommendation.
3. At least 60 days prior to the scheduled reappointment date, the Credentials Committee shall review all performance information available on each medical staff member scheduled for reappraisal and reappointment, and for the granting of clinical privileges for the ensuing period and shall transmit its recommendations, in writing, to the Medical Executive Committee.
4. At least 30 days prior to the scheduled reappointment date the Medical Executive Committee shall send written recommendations, along with all necessary documentation, to the Board of Trustees, through the Hospital Administrator, concerning the Medical Staff member's reappointment, non reappointment and/or changes in clinical privileges. The Board of Trustees shall make the final decision concerning reappointment.
5. If the decision of the Board of Trustees is favorable to the Practitioner, the Hospital Administrator will so notify, in writing, the Practitioner and the Chief of Staff. If the decision of the Board of Trustees is adverse toward the Practitioner, the Hospital Administrator will so notify, in writing, the Practitioner and the Chief of Staff.
6. The Practitioner may, if unwilling to adhere to the Board of Trustees' decision, exercise his/her rights under the Fair Hearing Plan as approved in these Bylaws.

ARTICLE V

CLINICAL PRIVILEGES

A. Delineation of Clinical Privileges

Every Practitioner at this Hospital by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically recommended by the Medical Executive Committee and granted to him/her by the Board of Trustees. Criteria for the delineation of privileges shall be developed and periodically revised by each clinical department.

1. Type I Privileges

To be eligible for type I privileges, the physician should currently hold "CONSULTANT" status in his/her clinical specialty and possess training and experience to manage difficult and complicated cases. No specific limitations are set forth by the Credentials Committee; however, if examination of Hospital records reveals unsatisfactory performance of certain procedures or case management, the Credentials Committee reserves the right to recommend curtailment or limitation of privileges.

2. Type II Privileges

To be eligible for Type II privileges, the physician should currently hold "SPECIALIST" status in his/her clinical specialty and possess training and experience to manage uncomplicated cases as acceptable to the Credentials Committee. Consultations will be required on all critical or seriously ill patients. Association with a "CONSULTANT" in these cases is required. This includes all patients in Intensive Care Units.

3. Type III Privileges-

To be eligible for Type III privileges, the physician should currently hold "Senior Medical Officer" status in his/her clinical specialty and possess the training and experience to admit and manage uncomplicated cases and perform minor procedures.

4. Type IV Privileges-

To be eligible for Type IV privileges, the physician should have completed a one (1) year internship and possess the training and clinical experience to admit and manage uncomplicated cases and perform minor procedures

B. Request for Clinical Privileges

Every initial application for Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, physical and mental health, and other relevant information, including an appraisal by the clinical department or section in which such privileges are sought. The applicant shall have the burden of

establishing his/her qualifications and competency in the clinical privileges requested.

C. Reassignment of Privileges

Biennial reassignment of clinical privileges and the maintenance, or curtailment of privileges, shall be based upon the observation of care provided and the review of medical records.

D. Increasing or Adding Privileges

A member of the Staff desiring increased or additional privileges shall apply in writing to the Credentials Committee. The application shall include documentation of relevant recent training and experience, and it shall be processed in the same manner as applications for initial appointment.

Relative to the physician's area of clinical specialty, privileges may be granted based on a checklist of specific procedures he/she desires to carry out. In particular, privileges for all invasive procedures or other hazardous practices should be granted on a specific procedure basis.

E. Privileges for Dentists

Privileges granted to dentists shall be based on their training, experience and demonstrated competence. The scope and extent of surgical privileges that each dentist may perform in Theatre shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists in Theatre shall be under the overall supervision of the Chief of the Department of Surgery. All dental inpatients shall have a history and physical. If medical problems are present, the dentist will seek medical consultation. A physician member of the Medical Staff shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization.

ARTICLE VI

DISCIPLINARY PROCEEDINGS AND SUSPENSION, REDUCTION OR REVOCATION OF CLINICAL PRIVILEGES

A. Grounds for Corrective Action

Whenever, on the basis of information and belief, the Hospital Administrator, Chief of the Medical Staff, the Chief of any Department or Committee Chairman has cause to question, with respect to a Practitioner's:

1. clinical competence;
2. care or treatment of a patient or patients, or clinical management of a case;
3. known or suspected violation of these Bylaws, Rules and Regulations relating to professional activity;
4. failure to comply with the ethics of his/her profession or the hospital policies;
5. behavior or conduct considered to be lower than the standards of the hospital;
6. failure or inability to work harmoniously with others to the extent that it affects the orderly and efficient operation of the hospital;

Any one of these may be cause for a request for investigation. All such requests shall be in writing, shall be made to the Chief of Staff who shall have responsibility for directing the process through which the complaint is resolved and any necessary corrective or disciplinary action against the practitioner is taken.

B. Investigation:

1. The Chief of Staff shall refer any matter related to professional performance to the Chief of the practitioner's clinical department or the Professional Activities Committee to attempt to obtain a solution of the matter without formal action.
2. The practitioner who is under investigation shall be invited to appear before the Department Chairman or Professional Activities Committee. Any such appearance shall be informal in nature in attempt to obtain a resolution of the matter without formal action. In any such case, the Chief of Staff shall notify the practitioner of the nature of the matter referred and the identity of any pertinent records and shall advise the practitioner that the matter will be submitted for formal proceedings under Article VIII of these Bylaws if it cannot be resolved at the informal stage.
3. Within fourteen (14) days after the receipt of the request, the Department Chief or the Professional Activities Committee shall forward a written report of the investigation to the Medical Executive Committee.

C. Medical Executive Committee Action

Within fourteen (14) days following receipt of the report of the investigation, the Medical Executive Committee shall take action upon the request. Such action may include, without limitation:

1. rejecting the request for corrective action;
2. issuing a warning, a letter of admonition, or a letter of reprimand;

3. recommending reduction, suspension or revocation of clinical privileges;
4. recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care;
5. impose terms of probation;
6. impose a requirement for consultation; or
7. recommend revocation of staff appointment.

D. Procedure Thereafter:

1. When the Medical Executive Committee after review of a report of investigation, or after review of summary suspension imposed pursuant to Article VII A, determines no corrective action be taken, the Chief of Staff shall report such determination to the affected practitioner, and the Board through the Hospital Administrator.
2. Any action by the Medical Executive Committee pursuant to Article XI C, or any combination of such actions, shall entitle the staff member to the procedural rights as provided in Article VIII, Fair Hearing Process of these Bylaws.

E. Reduction, Suspension or Revocation of Privileges:

1. Privileges or membership on the Medical Staff shall not be reduced, suspended, or revoked except in conformity with these Bylaws.
2. Practitioners engaged by the Hospital to provide clinical services to Hospital patients shall obtain appointment to the Medical Staff as provided herein. The clinical privileges and staff membership of such practitioners shall not be reduced, suspended, or revoked except as provided for other member of the Medical Staff unless otherwise stated by contract.

ARTICLE VII

SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

A. Grounds for Summary Suspension:

1. Whenever a staff member willfully disregards or substantially violates these Bylaws, Rules and Regulations, or other hospital policies, or whenever his/her conduct requires that prompt action be taken to protect the life of any patient or to reduce substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the hospital, or whenever the conduct or a practitioner materially disrupts the normal and efficient operations of any department

or unit of the hospital, the Hospital Administrator, Chief of Staff, or Chief of the responsible Department shall have the authority to suspend summarily the staff appointment, or all or any portion of the clinical privileges of such practitioner, and may take any necessary administrative action, including issuing a directive requiring the practitioner to cease his/her activities in the Hospital immediately and to leave the Hospital premises and denying the practitioner further access to hospital facilities and staff.

1.1 Immediately upon the imposition of a summary suspension, the Chief of Staff or the responsible Chief of Department shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension and until discharge. The wishes of the patients shall be considered in the selection of such alternative practitioner.

2. Such summary suspension shall become effective immediately and shall remain in effect for not longer than fourteen (14) days. Within that fourteen (14) day period the Chief of Staff shall promptly refer the matter to the Professional Activities Committee, which shall informally investigate the issues and hold such interviews as may be appropriate with respect to the affected practitioner and shall recommend to the Chief of Staff whether the suspension should be terminated.

3. The Chief of Staff, upon recommendation of the Professional Activities Committee, may terminate the suspension or action and permit the practitioner to resume exercising his/her usual privileges pending a resolution of the matter as provided below. Otherwise, the suspension or action shall remain in full force and effect. In either event, the suspension shall be referred to the Chief of Staff, who shall treat the matter as a complaint and proceed as provided in Article VIII (A).

3.1 The Hospital Administrator, the Chief of Staff, the Medical Executive Committee, and the Chief of the responsible Department shall be notified within seventy-two (72) hours.

4. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Executive Committee hold a Fair Hearing as provided in these Bylaws.

5. The Medical Executive Committee may recommend continuance, modification or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall be entitled to request an Appellate Review by the Hospital Board of Trustees as provided in these Bylaws.

B. Grounds for Automatic Suspension of Clinical Privileges:

1. Members of the Medical Staff are required to complete medical records within such reasonable time as shall be prescribed. The Hospital Administrator or his/her representative, or the Chief of Staff or his/her

representative shall impose a limited suspension in the form of withdrawal of admitting privileges and procedures until medical records are completed.

2. Action by the granting authority of licenses/certificates revoking a practitioner's license/certificate shall automatically suspend all of the practitioner's hospital privileges.
3. Failure to attend meetings as required in these Bylaws shall be considered as voluntary relinquishment of medical staff appointment and shall be sufficient grounds for refusing to reappoint the practitioner concerned. Such failure shall be documented and specifically considered by the Credentials and Medical Executive committees when making their recommendations for reappointment and by the Board when making their final decisions.
4. If the Board refuses reappointment, the practitioner shall be eligible to reapply for staff appointment and the application shall be processed in the same manner as if it were an initial application.

ARTICLE VIII

FAIR HEARING AND APPELLATE REVIEW

A. **Professional Activities Committee (PAC) Hearing Process**

1. The Professional Activities Committee (PAC) shall conduct a formal review of matters which may affect a practitioner's appointment, exercise of clinical privileges, or status as a member of the Medical Staff when so required by these Bylaws. Such review shall include a hearing unless waived by the affected practitioner.
2. Upon conclusion of its review, the PAC shall make a written report to the Medical Executive Committee setting forth the nature of the problem, the facts found by the Committee, and the Committee's recommendation for further handling including any corrective action. The affected practitioner shall promptly be sent a copy of this report.
3. When a matter has been referred to the PAC for formal proceedings, or when a practitioner's right to a hearing before the PAC otherwise arises under these Bylaws, the Chief of Staff shall provide written notice to the practitioner whose appointment, privileges, or status may be affected. The notice shall inform the practitioner of the matters under review and shall advise the practitioner that action may be taken affecting his/her appointment, exercise of clinical privileges, or status as a member of the Medical Staff and state the reasons therefor. The notice shall also advise the practitioner that he/she has a right to a hearing and shall summarize the practitioner's rights in the hearing.
4. The practitioner may obtain a hearing before the PAC by a request in writing to the Chief of Staff. Failure to request a hearing within 30 days of receipt of the notice required by paragraph three (3) above, shall be deemed a waiver of the right to a hearing and appellate review of the decision by the Board. If the affected practitioner has waived his/her right to a hearing, a hearing may nonetheless be held at the discretion of the PAC on its own motion.
5. When a hearing has been requested by an affected practitioner or scheduled by the PAC, the Chief of Staff shall give the practitioner no less than thirty-(30) days written notice of the date, time, and place of the hearing. The notice shall describe the matters to be considered at the hearing and the pertinent records, minutes, or documents to be reviewed, and shall include a list of the witnesses expected to testify at the hearing against the practitioner. A hearing may be held on less than thirty days notice if the practitioner consents.
6. The hearing provided by this section shall be conducted by a panel consisting of the entire PAC or any three or more members of the PAC designated by its Chairman, at the discretion of the Chairman. No one shall sit as a member of

a hearing panel, however, if he/she is in direct economic competition with the affected practitioner. This provision shall not preclude any person from appearing as a witness or expert witness at a hearing or from serving as a consultant to a hearing panel, provided that the person does not participate in the deliberations and decisions of the panel.

7, The hearing shall be conducted in accordance with rules and procedures adopted by the PAC and approved by the Medical Executive Committee of the Medical Staff. The hearing rules and procedures shall be designed to assure that any practitioner under investigation shall have full and sufficient opportunity to rebut and defend against any allegations presented and receive, in all respects, a fair and impartial determination of the hearing panel.

8, The rules and procedures shall provide that the practitioner has the right: 1) to representation by an attorney or other person of his/her choice; 2) to review records, documents, or minutes in advance of the hearing; 3) to be present throughout the introduction of evidence; 4) to call, examine, and cross-examine witnesses; 5) to comment on the contents of records and other documentary evidence submitted against him/her; 6) to present evidence determined to be relevant by the hearing panel; 7) to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof; 8) to submit a written statement at the close of the hearing.

9. Following the hearing the practitioner shall have the right to receive the written recommendation of the hearing panel, including a statement of the basis for the recommendation, and to receive the written decision of the Board of Trustees, including a statement of the basis for the decision, as elsewhere provided in these Bylaws.

10. In the absence of justification accepted by the hearing panel, the failure of a practitioner to appear at the time and place scheduled for a hearing shall be deemed a waiver of the right to a hearing and appellate review of the decision of the Board.

B. Medical Executive Committee Review

1. The Medical Executive Committee shall review the report of the PAC and in so doing, accept as true the facts found by the Committee and contained in its report. The Medical Executive Committee may accept, reject or modify the recommendations of the PAC for further handling including any corrective action. The Medical Executive Committee has full authority to issue a warning or a letter of reprimand, impose terms of probation or a requirement for consultation, or recommend to the Board of Trustees reduction, suspension, or revocation of clinical privileges or revocation of the practitioner's Medical Staff membership.

2. Upon conclusion of its review, the Medical Executive Committee shall make a written report to the in every case in which the Medical Executive Committee is recommending to the Board of Trustees action adverse to the privileges of the affected practitioner. The report shall include a statement of the facts found by the PAC, the recommendations, which were made by the PAC to the Medical Executive Committee, and the recommendation of the Medical Executive Committee to the Board of Trustees. The affected practitioner shall promptly receive a copy of this report.

C. The Hospital Board's Action

The Board of shall review the report of the Medical Executive committee. If the Board does not accept the recommendation of the Medical Executive Committee, the matter shall be referred to the Joint Conference Committee, which shall submit a final recommendation for action, by the Board. The decision of the Board shall be effective immediately unless the Board provides otherwise, and shall be communicated to the affected practitioner in writing, including a statement of the basis for the decision, with copies to the Medical Executive Committee and the PAC.

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D. Appellate Review

1. In all cases in which appellate review has not been waived, the affected practitioner shall have the right to request appellate review by the Board of its decision by delivering written notice of appeal to the Secretary of the Board within ten (10) days after receipt of a copy of the decision. The practitioner's failure to deliver timely written notice of appeal shall be deemed a waiver of the right to appeal.
2. Upon receipt of a timely notice of appeal, the Chairman of the Board shall assign the appeal for hearing by the entire Board sitting as a committee of the whole or by a panel of no fewer than three (3) Board members appointed by the Chairman. The appeal panel shall select a Chairman, and the practitioner shall be given no less than ten (10) days written notice in advance of the time, date and place of the appeal hearing.
3. The record on appeal shall consist of the written notices and communications exchanged in the course of the hearing and review process, the pertinent records, minutes and documents presented to and considered by the PAC. The failure of a practitioner to appear at the time and place scheduled for a hearing shall be deemed a waiver of the right to a hearing and appellate review of the decision of the Board.
4. An attorney or other person of his/her choice may represent the affected practitioner. Notice of appearance of such representative shall be

provided to the Chairman of the appeal panel no later than two (2) days prior to the scheduled appeal hearing.

5. The Chairman of the appeal panel shall have the discretion to appoint an attorney to act as counsel for the panel to advise on rules, procedures, and the scope of appellate review. All decisions concerning the conduct to the hearing shall be made by the appeal panel and announced by its Chairman.
6. Appellate review of the decision of the Board is limited to the following issues: 1) violation of Bylaws governing hearing and appellate review; 2) violation of rules and procedures for the conduct of hearings; 3) evident partiality or bias of the hearing panel; 4) arbitrary or capricious action by the PAC or the Medical Executive Committee in the determination of facts and recommendations for corrective action. Facts as found by the PAC, the Medical Executive Committee, or Joint conference Committee shall be final. The decision of the Board shall be communicated to the affected practitioner in writing, including a statement of the basis of the decision, with copies to the Medical Executive Committee and the PAC.

ARTICLE IX

CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be organized into the Active, Provisional, and Dental.

A. The Active Medical Staff shall consist of practitioners each of whom:

1. Meets the basic qualifications set forth in Article III
2. Shall be appointed to a specific clinical department
3. Shall be eligible to vote, hold office, and serve on medical committees as assigned
4. Admits patients to the Hospital according to his/her privileges

B. The Provisional Medical Staff

Although credentials are important, by themselves they are not a reliable criterion of competence. Every new member of the Staff should, therefore, be appointed on a provisional basis until his/her practices have been observed and approved as currently competent.

1. Provisional Medical staff shall consist of practitioners who have received their initial appointment, including those practitioners under employment contract for one (1) year or less. Members of the provisional staff:
   1.1 shall be assigned to a specific clinical department
   1.2 Shall serve on medical staff committees as assigned
   1.3 May admit patients according to his/her privileges

2. Members of the provisional staff shall be assigned to a specific clinical department where their activities will be monitored by the Department chief or his/her designee. The firsthand observations of the monitoring physician are critical to deciding whether it is appropriate to discontinue provisional status. This means that the monitoring physician's observations must be accurate and convey salient information on a number of items, including:
   - Proper pretreatment work up and documentation
   - Proper technique
   - Proper post treatment care and documentation
   - Timely completion of patient records
   - Adherence to Hospital policy and procedures
   - Clinical outcomes within acceptable levels of performance
   - Ability to handle complications, including consultation with other clinicians in appropriate situations
3. Clinical work of Provisional Staff shall be monitored by intermittently reviewing their charts and/or personal observation of a number and variety of cases that shall be of a sufficient extent that at the end of six (6) months the monitor can render a judgement as to the quality of the clinical work of the practitioner and give a written recommendation regarding the future status of the practitioner.

4. After the recommendation by the appropriate Department Chief and after review by the Credentials Committee and Medical Executive Committee, it may be recommended that:
   - the practitioner be granted Active status, or
   - be terminated from Medical Staff membership
5. Provisional staff members shall not be eligible to vote or to hold office.
6. During the provisional period, subject to the limitations and conditions of these Bylaws, a practitioner must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations of his/her staff category: and may exercise all of the clinical privileges granted to him/her.
   6.1 A practitioner's exercise of prerogatives and clinical privileges is however subject to any conditions or limitations imposed during this provisional period.

C. The Dental Staff shall consist of practitioners each of whom:

1. is duly certified/licensed to practice dentistry or oral surgery
2. shall not be eligible to hold office or vote on medical matters
3. may attend meetings of the Medical Staff and the department of which he/she is a member, serve on medical staff committees as assigned, and attend any Staff educational program.

D. The Visiting Medical Staff

1. The Visiting Medical Staff shall consist of acknowledged specialists who meet the qualifications as set for in Article III, but cannot fulfill the responsibilities, by choice or otherwise, of an Active member of the Staff. They may consult on a specific patient and be granted privileges in specific procedures upon that patient at the request of any member of the Medical Staff with the approval of the Administrator upon recommendation of the Chief of Staff.
2. Visiting Staff shall not have admitting privileges and are not eligible to vote or hold elective office. They may serve as consultants to committees and attend all Medical Staff meetings.

E. The Trainee Staff

1. The Trainee Staff shall consist of interns and elective students in numbers considered necessary for an adequate program as approved by the Board of Trustees.
2. Members of the Trainee Staff must be graduates of approved and recognized schools of medicine.
3. Trainee Staff shall be responsible to the director of their assigned programs, and shall conform to these Bylaws, Rules and Regulations.

ARTICLE X

CLINICAL DEPARTMENTS AND SECTIONS

A. Organization of Departments and Sections

1. The Medical Staff shall be organized into Clinical Departments, each as a separate component of the Medical Staff and shall have a Department Chief with the authority, duties and responsibilities as specified in this Article. All members of the Medical Staff shall be assigned to a clinical department (and section when appropriate).
2. The following clinical departments are established. Additional departments or sections within departments, the elimination, modification or combination of departments as required from time to time may be established by the Chief of Staff and the Board of Trustees after considering recommendations from the Medical Executive Committee.
   2.1 Dental

2.2 Ambulatory Medicine
2.3 Obstetrics and Gynecology
2.4 Pathology
2.5 Pediatrics
2.6 Radiology
2.7 Surgery (to include the following Sections)
Anesthesiology
General Surgery
Ophthalmology
Oral and Maxillofacial Surgery
Otolaryngology, (ENT)
Urology

3. Each clinical department shall have a Department Chief, a Deputy Chief, and Secretary for two (2) year terms elected by the members of the department and then recommended by the Medical Executive Committee to the Board of Trustees for formal appointment.
4. Chiefs of Pathology and Radiology may combine with other clinical departments in order to carry out their departmental responsibilities and staff functions.

B. Functions of Departments/Sections/Chiefs

Each Department Chief shall be accountable to the Chief of Staff and the Medical Executive Committee for all professional and administrative activities within his/her Department/Section, maintain continuing review of the professional performance of all practitioners with clinical privileges in the Department/Section, be responsible for enforcement of the Medical Staff Bylaws, Rules and Regulations within the Department/Section, transmit to the Credentials Committee the Department's recommendations concerning the staff classification, the appointment or reappointment, and the delineation of clinical privileges for all practitioners in the Department/Section. He/she shall report regularly on the activities of the Department/Section to the Medical Executive Committee.

1. The Department Chief provides leadership for the process measurement, assessment, and improvement of patient care within the Department/Section. These processes include: medical assessment and treatment of patients, use of medications, use of blood/blood components, use of operative and other procedures, efficiency of clinical patterns, and significant departures from established patterns of clinical practice. Regular reports shall be submitted to the Medical Executive Committee detailing such department analysis of patient care.
2. The Department Chief insures that members of the Medical Staff participate in the measurement, assessment, and improvement of other patient care processes. These processes include: education of patients and families, coordination of care with other practitioners and hospital personnel, and accurate, timely, and legible completion of patient's medical records.

3. Department Committees shall be established to assist the Department Chief in his/her functions and shall establish its own standards of medical practice and rules and regulations, subject to approval by the Medical Executive committee, consistent with the policies of the Medical Staff and of the Board of Trustees.
3. Each Department Committee shall establish a medical care evaluation program to fulfill its responsibility for evaluating the quality of medical services and selection of topics for presentation at the monthly departmental meetings that will contribute to the continuing education of every practitioner and to the assurance of optimal patient care.
4. The Department shall meet monthly, at least ten (10) times a year for the purpose to receiving, reviewing and considering the findings of the medical care assessment activities and the department's continuing education activities

ARTICLE XI

OFFICERS OF THE MEDICAL STAFF

A. Officers of the Medical Staff shall be:

1. Chief of the Medical Staff
2. Deputy Chief of the Medical Staff
3. Secretary/Associate Deputy Chief of the Medical Staff

B. Qualifications of Staff Officers

1. Officers of the Medical Staff must be members of the active staff and must remain members of good standing during their term of office. The officer should be a clinical consultant.

C. Selection and Appointment of Staff Officers

1. Officers of the Medical Staff are appointed by the Board in consultation with the Hospital Administrator and shall serve at the discretion of the Board.
2. All officers shall serve a two (2) year term from the date they take office or until a successor is named. Officers' terms begin on the first day of January, after their election.

D. Duties of Officers

1. Chief of Medical Staff
   - 1.1 Shall call and preside at all meetings of the Medical Staff and of the Medical Executive Committee, and shall be an ex-officio member of all Staff committees.
   - 1.2 He/she shall attend meetings of the Board and be responsible for the Medical Staff organization of the Hospital to the Board

1.3 He/she shall be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations and for implementation of sanctions where these are indicated.

1.4 He/she shall appoint committee members to all standing, special, and multi - disciplinary Medical Staff committees except the Medical Executive committee.

1.5 Shall be responsible for integrating the view, policies, needs and grievances of the Medical Staff with the Hospital Administration, providing day-to-day liaison on medical matters with the Hospital Administrator.

2. Deputy Chief of Medical Staff

2.1 The Deputy Chief of Staff succeeds the Chief, and, in the absence of the Chief, shall assume all the Chief's duties and have all his/her authority.

3. The Medical Staff Secretary

3.1 The Secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the Chief, attend to all correspondence, and perform such other duties as ordinarily pertain to the office. If there are funds to be accounted for, he/she shall also act as Treasurer.

3.2 Should both the Chief and Deputy Chief of the Medical Staff be unavailable in an emergency, the authority and duties of the Chief of Staff will be temporarily assumed by the Secretary/Associate Deputy Chief.

ARTICLE XII

OFFICERS OF CLINICAL DEPARTMENTS

A. Chiefs of Departments/Services

Each Clinical Department shall have a Chief appointed by the Chief of the Medical Staff. The Department Chief shall be an experienced Consultant with administrative ability for the position, and be a member of the Active Staff.

1. Term of Office: A Department Chief shall serve a term of two ((2) medical staff years. The Chief shall be eligible to succeed himself/herself. Removal of a Department Chief from office may be initiated by a two-thirds vote of all Active Staff members of the Department, but no such removal shall be effective until recommended by the Medical Executive Committee and approved by the Chief of the Medical Staff and Board.

2. Duties:

Each Department Chief shall:

2.1 Be responsible for the organization of all departmental activities and for the general administration of the department;

2.2 Be responsible for enforcement of the Medical Staff Bylaws, Rules and Regulations, and Hospital policies;

2.3 Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding patient care in the department which he/she represents;

2.4 Maintain an ongoing review of the professional performance of all physicians with clinical privileges in his/her service and report regularly thereon to the Medical Executive Committee; make recommendations to the Staff Credentials Committee concerning appointment and category, reappointment, delineation of clinical privileges, and corrective action with respect to applicants to, and staff members of, his/her department;

2.5 Enforce Hospital policies, the Medical Staff Bylaws, Rules and Regulations, and policies within his/her department, including initiation of corrective action and investigation of clinical performance and ordering required consultations;

2.6 Participate in every phase of administration of his service through cooperation with the Nursing Service and Hospital Administration in matters affecting patient care, including personnel, supplies, equipment, special regulations, standing orders and techniques;

2.7 Assist in the preparation of such annual reports pertaining to his/her department as may be required by the Chief of Staff, Hospital Administrator, and Board of Trustees;

2.8 Be responsible for any teaching, continuing education and research programs in his/her department;

2.9 Participate in the development of clinical guidelines to be used in the monitoring and evaluation of the quality and appropriateness of medical care provided to patients by members of his/her department;

2.10 Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff.

ARTICLE XIII

COMMITTEES OF THE MEDICAL STAFF

There shall be such standing and special committees of the Medical Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Bylaws or necessarily incidental thereto. All Medical Staff members to serve on committees and committee chairmen shall be appointed by the Chief of Staff. The Hospital Administrator shall appoint all other hospital personnel. The Chief of Staff and the Hospital Administrator shall be member's ex-officio of all committees. Committee appointments are for two (2) years, coinciding with the medical staff year.

All committees shall:

- Meet monthly- at least ten (10) times per calendar year
- Maintain a record of attendance
- Maintain a record of their activities
- Submit timely reports of their activities to the Medical Executive Committee

A. Medical Executive Committee

1. Composition:
   The Medical Executive Committee shall be a standing committee and shall consist of the Officers of the Medical Staff, The Chiefs of Departments, Chairman of the Credentials Committee, Chairman of the Quality Improvement Committee, two (2) members of the Active Staff at large and the Hospital Administrator shall serve as member ex-officio.
2. Duties:
   - 2.1 to represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;
   - 2.2 to receive and act upon committee reports, departmental reports and t o make recommendations concerning them to the Chief of Staff;
   - 2.3 to coordinate the activities of, and policies adopted by the Staff, departments and committees;
   - 2.4 recommend to the Board through the Hospital Administrator, all matters relating to Staff appointment, reappointment, delineation of clinical privileges and corrective action;
   - 2.5 account to the Board and the Medical Staff for the overall quality and efficiency of medical services and patient care in the Hospital;
   - 2.6 initiate and pursue corrective action, when warranted, in accordance with these Bylaws;
   - 2.7 implement policies of the Medical Staff not otherwise the responsibility of the departments;
   - 2.8 review annually and revise as necessary these Medical Staff Bylaws.

3. Meetings, Reports and Recommendations:
   This committee shall meet at least once a month; the secretary will maintain reports of all meetings, including the minutes. Summary reports and important actions will be transmitted quarterly to the Medical Staff and to the Board of Trustees.

B. Professional Activities committee

1. Composition:
   The Professional Activities Committee shall consist of seven (7) members of the Active Staff nominated by the Chief of Staff and appointed by the Board.
2. Duties:
   - 2.1 The Committee shall serve as the principal investigative and hearing body of the Medical Staff
   - 2.2 The Committee shall receive, evaluate and report with recommendations upon complaints relative to professional performance and conduct of members of the Medical Staff.
   - 2.3 The committee may conduct interviews with those concerned and may obtain assistance in investigations from clinical departments and sections and from medical care evaluation committees.
   - 2.4 The Committee may investigate any complaint involving a practitioner that is referred to it by the Chief of Staff for resolution without formal action.
   - 2.5 Carry out the duties and functions of institutional review for all investigative and research proposals which will involve patients (medical ethics review)
   - 2.6 The Committee shall conduct formal proceedings as provided in Article VIII
3. Meetings, Reports and Recommendations:
   The Committee as a whole shall meet on call, and meetings of the Committee shall be reported to the Medical Executive Committee.

C. Medical Records Committee

1. Composition:
   The Medical Records Committee shall consist of at least five (5) members of the Medical Staff appointed by the Chief of Staff. Included on the Committee, as non-voting members are representatives of Medical Records Department and Nursing.
2. Duties:
   - 2.1 The Committee shall supervise and appraise medical records assuring that all medical records meet the highest standards of patient care usefulness and historical validity.
   - 2.2 The Committee shall evaluate the quality of medical records in the Hospital and shall take necessary action to ensure maintenance of the records at the required standards for promptness, completeness, legibility and clinical pertinence.

2.3 The Committee shall recommend to the Medical Executive Committee any new rules and regulations necessary for improvement of the medical records and medical care in the Hospital.

2.4 The Committee shall report to the Chief of Staff the names of any Medical Staff members who are persistently delinquent in completion of their records.

3. Meetings, Reports and Recommendations:
The Committee shall meet every two-(2) months, and shall make a report to the Medical Executive Committee of its activities.

D. Infection Control Committee

1. Composition:
The Committee shall consist of three (3) members of the active staff and one should have an interest in infectious diseases. Representatives from Nursing, hospital administration, and the individual/officer directly responsible for the program should be included.
2. Duties:
2.1 The Committee is multidisciplinary which oversees a program for surveillance, control, and prevention of infection.
2.2 The Committee shall design and promote a preventive and corrective program to minimize infection hazards.
2.3 The Committee shall evaluate and make recommendations regarding any change in methods, agents and procedures for cleaning and sterilizing.
2.4 The infection control officer through the Committee Chairman shall have the authority to institute any surveillance, prevention, and control measures or studies deemed necessary to assure the safety of patients and healthcare workers with regard to infectious agents. Such actions will be reported to the Infection control Committee for review and approval.
2.5 The Committee approves actions to prevent or control infection based on:
- An evaluation of prospective and retrospective analysis of infection surveillance data;
- An evaluation of the infection potential among patients and healthcare workers; and
- The analysis of data gathered through special studies designed to investigate unusual infection control problems.

3. Meetings, Reports and Recommendations:
The Committee shall meet monthly and report its findings to the Medical Executive Committee.

E. Pharmacy and Therapeutics Committee

1. Composition:
The Committee shall consist of three (3) members of the active staff, the Chief Pharmacist, and representatives from nursing and administration.
2. Duties:
2.1 Develop and maintain a hospital drug formulary or list of drugs for use in the hospital.

2.2 The Committee shall study problems of storage, distribution, labeling, and control/drug management.

2.3 The Committee shall recommend to the Medical Executive committee rules and regulations and policies regarding the safe use of drugs in the Hospital including such matters as stop orders, investigational drugs, hazardous drugs and others.

2.4 Review appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics in the hospital.

2.5 Develop policy and procedure for the evaluation, selection, distribution, handling, use of, and administration of drugs.

2.6 The Committee will review all untoward drug reactions.

3. Meetings, Reports and Recommendations:
   The Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

F. Utilization Review Committee

1. Composition:
   The Committee shall consist of five (5) members of the active staff representing separate clinical departments, and a representative from administration, nursing and medical records.
2. Duties:
   2.1 The Committee shall develop and maintain a utilization program designed to evaluate the appropriateness of patient admissions to the hospital, continued stay of selected cases, discharge practices, use of medical and hospital services and all other factors relating to the utilization of hospital and physician services.
3. Meetings, Reports and Recommendations:
   The Committee shall meet monthly and report its findings to the Medical Executive Committee.

G. Continuing Medical Education Committee

1. Composition:
   The Committee shall consist of representatives of the clinical departments appointed by the Chief of Staff.
2. Duties:
   2.1 To develop a plan and participate in programs of continuing medical education that are designed to keep the medical staff informed of significant new developments and new skills in medicine and that are responsive to the findings of the patient care review activities

   2.2 To act upon recommendations from the Medical Executive Committee and the clinical departments.

   2.3 To coordinate when appropriate with teaching institutions.
3. Meetings, Reports and Recommendations:
   The Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

H. Patient Care Committee

1. Composition:
   The Committee shall consist of at least seven (7) members of the Medical Staff representing the clinical departments of Family Medicine, General Medicine, Obstetrics/Gynecology, Pediatrics, Surgery, Pathology and Radiology, as well as, Committee Chairmen of Infection Control, Pharmacy and Therapeutics, Medical Records, Transfusion and representatives from Nursing and Administration.
2. Duties:
   - 2.1 Responsible for the general oversight, coordination and integration of the ongoing process of monitoring, evaluating and improving the quality of patient care at this Hospital.
   - 2.2 Designing a program for assessing and improving the quality of patient care and services.
   - 2.3 Reviews the findings and recommendations of departments, committees and other Staff activities designed to monitor clinical practices and patient care to detect trends, patterns of performance or potential problems that affect medical services or patient care.
   - 2.4 To follow up on opportunities for improving patient care and monitor identified problems to assure improvement or resolution (especially high volume cases, problem-prone cases and difficult cases).
3. Meetings, Reports and Recommendations:
   The Committee shall meet monthly and report its activities, findings and recommendations to the Medical Executive Committee and to the Hospital Board through the Hospital Administrator.

I. Credentials Committee

1. Composition:
   The Committee shall consist of the Deputy Chief of Staff, who shall be the Committee Chairman, and five (5) members of the Active Staff representing the various clinical departments who are not members of the Medical Executive Committee.
2. Duties:
   - 2.1 To review the credentials of all applicants for Medical Staff membership and clinical privileges, including the recommendations from the department(s) in which such applicant requests privileges.
   - 2.2 To make such investigations of and interview applicants as may be necessary, and to make recommendations to the Medical Executive Committee for appointment and delineation of clinical privileges in compliance with these Bylaws.
   - 2.3 To review, as questions arise, all information available regarding the professional and clinical competence of persons currently appointed to the Medical Staff, their care and treatment of patients and case management, and as a result of such review, make recommendations to the Medical Executive Committee for the granting, reduction or withdrawal of

promotions, privileges, reappointment, and changes in the assignment of appointees to the various departments.

3. Meetings, Reports and Recommendations:
The Committee shall meet as necessary to accomplish its duties. The Committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee.

J. Bylaws Committee

1. Composition:
The Committee shall consist of Chief of the Medical Staff and at least four (4) members of the active staff.

2. Duties:

2.1 Conduct at least a biannual review of these Bylaws, Rules and Regulations and related manuals and forms promulgated in connection with them.

2.2 The committee shall meet as required to consider revisions and amendments to these medical staff Bylaws or as directed by the Medical Executive Committee.

2.3 The committee shall submit written recommendations for revision to the Medical Executive Committee.

ARTICLE XIV

MEETINGS OF THE MEDICAL STAFF

A. The General Staff Meeting

The Medical Staff shall meet at least every three (3) months on dates and times set at the beginning of the year by the Chief of Staff for the purpose of reviewing and evaluating departmental and committee reports and recommendations, and to act on any matters placed on the agenda by the Chief of Staff.

One (1) General Staff Meeting shall be held in the last quarter of the year. Business of the Medical Staff shall be conducted at this meeting. Retiring Officers, Department Chiefs and Chairman of Committees shall make such reports and recommendations as may be desirable. In addition, the clinical work of the Hospital shall be reviewed and reports and recommendations from the Medical Executive committee, departments, committees shall be given as well as the Administrator's report.
In an election year, the Nominating Committee shall present nominations for officers and Members-at-Large for the Medical Executive Committee, and additional nominations shall be permitted from the Active and Provisional Staff.

The order of business and agenda are:

- Review and approval of minutes of the last meeting
- Old business
- Administrative Report from the Hospital Administrator
- Reports by officers, departments and committees on the overall patient care review activities other maintenance activities of the staff and other required staff functions
- New business
- Educational program
- Adjournment

B. Special General Staff Meetings

Special meetings of the Medical Staff may be called at any time by the Board of Trustees, the Chief of Staff, the Medical Executive committee or by petition of ten percent (10%) of the members of the Active and Provisional Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. Sufficient notice of a special meeting shall be made to each member of the Medical Staff at least seventy-two (72) hours prior to the time set for the meeting.

The agenda for special meetings shall be:
- Reading the notice calling the meeting
- Transaction of business for which the meeting was called
- Adjournment

C. Meeting Quorum

A quorum must exist for any action to be taken. The presence of fifty percent (50%) of the total active medical staff membership at any regular or special meeting shall be necessary for purposes of amending these Bylaws, Rules and Regulations. The presence of thirty percent (30%) of such membership shall constitute a quorum for all other actions.

For meetings of the Medical Executive Committee, fifty percent (50%) of the voting members of the committee.

For committee and department meetings, those present and voting.

D. Minutes

Minutes of each meeting of the medical staff, its departments and committees shall include a record of attendance, the outcomes of the vote taken on any matter, other findings and recommendations.

Minutes shall be signed by the presiding officer or chairman and forwarded to Hospital Administration for permanent filing.

E. Attendance

Each active and provisional member of the Medical Staff is expected to attend all meetings of the medical staff and applicable department and committee meetings. Participation in Medical Staff activities may be used by the Credentials Committee in evaluating members at the time of reappointment.

Each active and provisional member shall be required to attend:

- At least 75% of all staff meetings each year; and
- At least 75% of each committee and department meeting of which he/she is a member

ARTICLE XV

RULES AND REGULATIONS

The Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to approval by the Board. The Medical Executive Committee upon recommendations of the various departments, sections, and committees shall formulate the Rules and Regulations. They shall be effective when approved by the Board.

The Rules and Regulations shall be a part of these Bylaws. They may be amended, changed or deleted by action of the Medical Executive Committee with the approval of the Board of Trustees. Any changes in the Rules and Regulations of the Medical Staff shall be published and distributed to the Medical Staff.

Notwithstanding the foregoing, no Rule or Regulation shall be valid to the extent that it conflicts with any provision of these Bylaws.

ARTICLE XVI

ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

A. Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate and to submit recommendations to the Board regarding the Medical Staff Bylaws and amendments thereto. All amendments or revisions shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. A standing committee of the Medical Staff shall review the Medical Staff Bylaws at least annually.

B. Methodology

The Bylaws may be adopted, amended or repealed by a majority of those active members of the Medical Staff present at a meeting at which a quorum is present, provided that a proposed text of the amendment was submitted in writing at the previous regular business meeting.

C. Adoption

The Medical Staff Bylaws with the appended Rules and Regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Hospital Board.

ADOPTED BY THE MEDICAL STAFF:

DATE: _____

Chief of Medical Staff: _____

Deputy Chief of Medical Staff: _____

Medical Staff Secretary: _____

APPROVED BY THE HOSPITAL BOARD:

DATE:_____

Chairman:_____

Secretary:_____

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end